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Discourse and Forensic Learning Disability Nursing Practice: Ideology, Paradox and Truth

School of Health, Community and
Education Studies

This thesis is submitted in partial fulfilment
of the requirements of the University of
Northumbria at Newcastle for the degree
of Doctor of Nursing Science

Pamela Anne Inglis
November 2008

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work.

Name: Pamela Anne Inglis

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Date:

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Abstract

TITLE: Discourse and Forensic Learning Disability Nursing Practice: Ideology, Paradox and Truth. Pp 310, appendices 14.

OVERVIEW: Central to successful therapeutic relationships in working with people with a learning disability is the language used by nurses; the discourses which they create and perpetuate; and resultant implications for practice. These are key issues in the current investigation. Employing retrospective data obtained during an action research programme carried out in a medium security forensic unit (MSU), it analyse types of discourse employed by the men who reside there and the staff. Part of the analysis shows having a learning disability as viewed through the eyes of the men themselves in a study extending over twenty months. Literary analyses on method, representations of learning disabilities, security and discipline, and forensic practice were carried out concurrently.

AIMS: These are to (1) develop a critical and a post-modern approach to investigating given 'truths' about; the positives of learning disability; men with learning disability who offend; and the nature of forensic nursing: (2) develop a socio-political overview by applying critical discourse analysis to examine micro discourses and macro models associated with learning disabilities, related national and local policies, and models of nursing and disability: (3) combine the products of (1) and (2) to illustrate discourse, repertoires, paradoxes and practical ideologies justifying treatment in the MSU, revealing ideologies and beliefs regarding learning disabilities in this setting.

THEORY AND METHOD: Foucault shows how linguistic constructions, written protocols and customary oral dialogue are used to create and sustain dominant views of 'reality' – and may also be used to challenge these. Retrospective data regarding six men living in the MSU and their staff [total **N=17**] were obtained using diaries, observational notes, semi-structured interviews, focus groups and evaluations originally collected as part of an action research project. National and local policies were also interrogated. Data were then reanalysed using critical discourse-analytic techniques.

OUTCOMES: Findings suggest that the men are viewed paradoxically. On one hand, they are seen negatively as different, dangerous, lacking ability: and staff as custodians restricting their rights. Paradoxically, affirmative discourse is also abundant – the men are talented and pleasant

companions. Repertoires illustrate warm therapeutic relationships existing between the men and staff, demonstrating 'good nurse' characteristics expressed within a complex and restrictive environment, with humour playing an important part. These paradoxical repertoires reveal practical ideologies which defend forensic practice and justify treatment. Results have implications for the men (their views are acknowledged and disseminated); for practice through enhancing the evidence base; for nurse education through reflection on ideologies and justifications on which forensic practice is based.

Preface

It is important for me personally and academically (for reasons such as transparency, honesty and the Foucauldian stance taken), that I begin this thesis by informing the reader of my views and reasons for my interest in learning disability and discourse. This preface should be called "Reasons why I do what I do".

The simple answer is that I grew up with an aunt with Down's syndrome. Her given name was Patricia; affectionately known as Treesha. I have spent my whole life with people with a learning disability, one way or another – I wouldn't have it any other way. You see, I would argue that learning disability has advantages for the individual and society and I reject the tragedy discourses of learning disability. I do not, though, set out to disregard or minimise the disadvantages that people with a learning disability may encounter in our society, it is just that most of the literature pertaining to this field constantly state negative issues. Therefore, deliberately, I will not.

Treesha was born weighing two pounds, and my Grandmother was told by the doctors and nurses not to bother to feed her as she wouldn't survive and would be unable to do anything. Fortunately, my feisty Grandmother ignored them. According to the medical profession, as Treesha grew, she was not going to survive past one year, then five years and then her teenage years. The tragedy discourses about disability dominant in the medical profession did not exist in my family.

One of my first memories is being at Treesha's birthday bash – invariably loud occasions attended by a devoted and large extended family. It was quite clear from the outset that Treesha came first. I was never under any illusions, as we were all taught early on that Treesha was the centre of the family. The values I was socialised into as a child included the 'fact' that Treesha (and people like her) were 'special' people, sent as a gift from God. As it turned out, she was indeed a gift of joy to the whole family.

Treesha was to be protected, respected for who she was and, above all, loved. Treesha had the best of everything my family could afford. She would eat pounds of sausages, loaves of bread and jars of

jam in one sitting. She was extremely happy, loud and robust, with a wicked sense of humour and a keen eye for anyone else's weaknesses. Treesha had an innate ability to cut to the chase – never blessed with social graces – and she would often gleefully insult family, friends and visiting priests, especially if they dared to stay over what should have been her tea time.

Treesha remained protected - she never went to school and would often be horrified at the mere mention of the word, or the place where the 'man from the school board' suggested she could go (he turned up when she was in her twenties to offer her a place in a school which had just been established). It was an educational enterprise in Durham (or "Dirty Rotten Durham" as it became affectionately known ever-after). Treesha never left her mother's side, even sleeping together, until my Grandmother died when I was eighteen months old. Treesha went on to be cared for by her surviving siblings.

My childhood is filled with her memories, her sayings, her boundless sense of fun; the 'parcels' she would wrap, the shiny things she would 'procure' from any house which she was visiting, the songs she would sing. The clothes which she would rip, the names she had for everyone; my mother (Rita) was called 'Weet', my father was affectionately known as 'dirty rotten pie face'. She called me Pame-lame-lamela.

She had an imaginary friend who she chose to communicate with most of the time that she wasn't communicating with real people. She called him Pa'ah. Poor Pa'ah got the blame for most things. Pa'ah always travelled with her and she confided in him, laughed at him and told him off in equal measure.

Just before Treesha died, it was my mother's 'turn' to care for her. In her fourth decade of life Treesha deteriorated quickly, almost before our eyes. This robust, loud, wonderful person disintegrated in mere months. She lost huge amounts of weight and went blind. The epilepsy she had as a baby, returned with a vengeance. My parents and her other siblings watched in despair, powerless to save their beloved Treesha. The details are still too painful for me to recall here. Suffice to say Treesha died when I was fifteen. I was devastated; and still am.

I have often asked myself why Treesha affected me so profoundly as to carve my career, my passion and my life – why only me out of a huge extended family? Was it my age when she died? Was it that it was the first and only time I ever saw my parents helpless? Or was it that she just touched me in such a way that I still can't shake? Anyway, it is matter-less, Treesha is the reason I do what I do.

What follows is an extract from my personal memoirs of Treesha which explains how I feel, and may give the reader an insight into my perspective of learning disability.

My aunt Treesha was one of the world's beautiful minds. A simple, non-judgmental view of the world that touched all who knew her. Treesha did not know she was different. Indeed, she barely knew the impact she had.

The woman who showed me how I could be... Or even how I should be... the woman I aspire to, but because of the blight of my intelligence, and what the cynical world has taught me, could never be.

She touched our lives as a child who died, even though she was 48; without blame or shame; only regret that she was no more.

My aunt called Treesha who had Down's syndrome, died when I was fifteen.

Patricia Mullen was born to a working class Irish family in the 1930s, the fourteenth child of first generation Irish immigrants. This is part of my memories of Treesha, who I was honoured to know. Judge for your selves if you feel her life was fulfilling, if she was worth knowing; if she had a beautiful mind....

Treesha, Treesha and Pa'ah. Her best and most imaginary friend. She carried him always in her conversations; she fought with him frequently, and laughed most heartily at his jokes.

Pa'ah, how I wish I could have met him, or even come to know who he represented.

Treesha;

Who wouldn't wear her wig, except, perhaps backwards if bribed.

Who wore big quilted coats and brown leather sandals.

Who was dressed in frocks with socks, and looked wonderful!

Who was seven foot tall, but only four foot in height!

Who sat cross-legged on the sofa, chewing her thumb between her empty gums.

With a bald head and no eyebrows or eyelashes, where the hypothyroidism, took its toll.

With eyes of epicanthic folds, that widened when she laughed.

With outstretched palms, with simian crease, small fingers which explored the world and offered a loving touch.

Who had a smile which can still make me cry with happiness at its mere memory; nineteen years and four months after I last looked upon it. As I cry now, when remembering it. (Inglis, 2000, unpublished).

Because of Treesha's influence I grew up wanting to do one thing; to work with people with a learning disability. I worked voluntarily until I left school and at sixteen and got a job on a Youth Training Scheme (YTS) working in Adult Training Centres for people with a learning disability and loved it. At eighteen, realising I did not know enough, I began to look for a further education course which would help me to do my job better. To my surprise, I found that there were specialist nurses for people with a learning disability. I had never wanted to be a nurse – it had always seemed a bit *cliché* for a girl. Despite this, at eighteen years old I commenced nurse training, specialising in people with a learning disability. Wolfensbergers' normalisation discourse was at its height and I trained at the beginning of the transition from hospital-based care into community care. It was during this time that nursing for people with a learning disability was changing and the profession was moving away from the medicalisation of learning disabilities towards a more medico-social approach. I knew right away that I did not want to work in the big institutions, but in the community where people with a learning disability might enjoy acceptance and an existence closer to what I had experienced with Treesha as a child.

When my training ended I began work at a local community hospital. By then I was married and had the first of three beautiful daughters (the first born; Kaydii Patricia - named after Treesha). After four more years I realised that I still did not know enough to do the best job that I could, so I embarked upon a full time psychology/sociology joint honours degree.

It was during this time that I began to develop an interest in criminology as part of my studies. In fact upon Graduation I began teaching criminology and health psychology at the same university and began an MPhil, and eventually a PhD in the profiling of burglary. In time, I had many part time jobs teaching in higher and further education, including teaching people with a learning disability in a local college for a few hours a week, which I loved. During this time there was a pull - I still worked on the nurse bank. Eventually, when the pull was too great I went back to nursing as my main job, and teaching as a part time post. You see, I didn't nurse because I primarily want to 'do good' or to 'help' – I loved nursing because of what *I got out of it*, not because of some romanticised ideas of giving myself to help others or other such altruistic nonsense. It was quite a selfish thing.

Finally, a post became vacant for a lecturer/practitioner in learning disability nursing at a local university. I was interviewed and to my surprise they offered me a full-time senior lectureship instead. It was a difficult decision for me as this post would mean for the first time in my life I would not be in regular contact with people with a learning disability. I accepted the post, and a major part of my decision was based upon the potential impact that I may have on the future of learning disability nursing – a potential I could not ignore.

I am passionate about my profession. I feel that nurses mostly do a great job under difficult circumstances, but also nursing people with a learning disability has its own rewards which are alluded to later in the preface and in the thesis. I also believe that nurses are almost as susceptible to the discourses surrounding people with a learning disability as they are. Nurses have to negotiate their work within policy and practice that is steeped in historical ideology and discourse. This is also addressed later in the thesis. The next two years were busy, but were also almost a grieving process, as I eventually weaned myself off nursing practice and consequently, also off regular contact with people with a learning disability.

In 2000 I was given an opportunity to go to see Wolf Wolfensberger giving a series of lectures in the local city. I was appalled and disappointed with the material that was being peddled at these lectures. I felt aggrieved that learning disability nursing practice was ideologically based upon such material, which I had previously viewed as being responsible for so many positive changes in the lives of

people with a learning disability. Whilst it is acknowledged that Wolfensberger's work had had a positive effect upon services for people with a learning disability all over the world, I was quite disturbed by some of Wolfensberger's more radical ideas. Two of the worst follow:

- He suggested that learning disability was not a good term as 'dis' means death or absence of, and it was clear that people with a learning disability were not dead and that they could learn. However, his preferred alternative term, 'the naturally stupid' was insulting, and he had little sound argument defending it.
- Furthermore, one afternoon he suggested that one of the 'first signs of learning disability' was gaping. As he described his theory that people with a learning disability should be discouraged from gaping to avoid being devalued – behind him on a giant screen flashed pictures of children and adults with various syndromes (some not associated with learning disability) gaping to illustrate his point. In amazement, I looked around the room at my fellow professionals to judge their response. I counted six people gaping at Wolf. I was one of them.

So began my interest in exactly what Wolfensberger stood for, and my mission to find an appropriate alternative for learning disability nursing.

Then life happened. Suddenly I became ill. No one could explain it. I couldn't get out of bed for three months the first time. This was reduced to ten weeks the next few times. The pain was excruciating, but the tiredness was the worst – it meant I couldn't care for my children. It broke my heart that my thirteen year old daughter and ten year old twin daughters (Helen and Lana) had to care for me instead, along with my wonderfully supportive husband (Paul), mother, sister (Theresa), family and friends. Eventually, after four different diagnoses, I was diagnosed with psoriatic arthritis. The doctors believed that I had probably had it all of my life. I was hospitalised as an infant and although later very active and athletic, I had to give up sport as a teenager because of 'knee trouble' that was never fully investigated. I just got used to the pain, I suppose.

I was poorly for the next three years until the pain and the progression of the disease were eventually controlled to a degree where I could function – pain relief and lifestyle adjustments became my new 'normal'. My PhD suffered along with my health. I was shattered.

However, eventually, I was offered an opportunity to work on a local study for the department of health, which included men with learning disabilities living in forensic settings. At last my two great passions collided – I couldn't let this opportunity pass.

Around this time I had become extremely interested in the politics of disability, especially the affirmation model proposed by Swain and French (2000). When I first read this article, I was bowled over – at last someone was articulating how I had always felt, but could not express adequately. Their main argument is summed up thus:

'We are who we are as people with impairments, and might actually feel comfortable with our lives if it wasn't for all those interfering busybodies who feel that it is their responsibility to feel sorry for us, or to find cures for us, or to manage our lives for us, or to harry us in order to make us something we are not, i.e. 'normal'.' (Colin Cameron. Tyneside Disability Arts; 1999; 35. Cited Swain and French; 2000; 577).

The affirmative model rejects the personal tragedy model of disability and its images of dependency and abnormality. It shows a positive identity through rejection of the dominant view of normality. It challenges the value-laden views of society, which see the disabled experience as one of tragedy; it asserts the value and validity of the life experiences of those with a disability as a liberating, positive, part of their identity.

As Swain and French were expressing essentially what I had always believed, this is in essence where this doctoral thesis began.

The Study

The topic of this thesis is the discourse related to forensic practice with people with a learning disability, which is a subject approached rarely in the literature. The purpose of the study is to explore the 'truths' about people with a learning disability detained in these settings (referred to here as 'the men') and the staff who work with them through analysing the discourses contained in retrospective data from interviews and focus groups.

I feel that the men are subject to intense stigma and disadvantage; socially and legally. Not only are they categorised as having a learning disability, but also have the added stigma of being

offenders, and commonly having mental health issues which expose them to the worst of myths surrounding learning disability; such as being viewed as dangerous monsters and sex fiends (French and Swain, 2008). I set out deliberately to expose the positive aspects of learning disability and of working with this population, which are topics commonly absent in the literature. Similarly, but to a lesser degree, forensic nurses are stigmatised and subject to strict laws, policies and practices and stereotyped as prison wardens and tough guys.

These ideas may be exposed and challenged through studying the discourses surrounding forensic practice. Therefore the general research questions are:

- ***What are the discourses related to learning disability and forensic practice?***
- ***What are the positive discourses?***
- ***What ideologies underpin and justify forensic practice?***
- ***What does this mean for the men, future practice and nurse education?***

Because of the negative ways in which they are generally viewed, it may be more difficult for people with a learning disability to acknowledge the positive discourses, than the rest of society:

*"We can give them drugs which may ameliorate their anguish (at the absence of truly loving or accepting relationships), we can rehabilitate them to certain social competencies. But the most important thing we can offer...is an assurance that we want them with us **as they are**". (my emphasis), (Shearer, 1976;32-33, cited Baroff, 2000;75).*

Here Shearer is discussing the importance of acceptance for people with a learning disability; just as it is important in the lives of all other people. This thesis will show that there are many positive attributes held by the people in this study and I will argue that if it is possible to expose such attributes in people living in secure settings, then it should be possible to expose positive characteristics, abilities and attributes held by people with a learning disability, living anywhere.

This study will show that therapeutic relationships flourish in forensic settings, as much as they do in any other health environment, through exploring the relationships which exist between the men and the staff who participated. Some negative discourses can and will be challenged. An important way to dispute negative discourses of difference is through emphasising ability above deficit:

*'The major barrier is **attitude**. People see our disability only, they do not see our ability. We may have a handicap but we are not the handicap'. (Pat Worth (Canadian self-advocate) in Yarmol, 1987; 28, Cited in Goodley, 1998; 443).*

Positive Discourses of Learning Disability

After working with people with a learning disability for several years an ex member of the British Eugenics Society commented that [they]:

'Show such a variety of virtues – generosity, altruism, good will, sweet temper – that I began to think that a world peopled by mentally defectives might be an improvement on the present one'. (Cited Goodley, 2001b; 28).

Of course, by describing the positive aspects of people with a learning disability one may fall into the same trap as negative discourses do; by generalising about people with a learning disability, a group is created, and individuality and difference is lost. Additionally, I am an academic who is commenting on others – I cannot really speak on their behalf. Despite these risks, I feel that it is an important aspect of this study to try to counterbalance the negative discourses about people with a learning disability, especially those living in secure environments.

In this thesis I will do this through the literature, the statements of self-advocates and through the words of the participants in this study. The rest of this chapter will explore the positive discourses about people with a learning disability described through their attributes of capacity for creating and giving love and a celebration of positive differences.

'...it's the same as using Down's syndrome...so that everyone can recognise the term. This lady who had a Down Syndrome baby, he died when he was two, and she wrote a book about it. It's a true story...and I know her very well. She is a lovely lady, amazing, and she was totally thrilled when she met me because I have Down's Syndrome. She really wanted to see someone with it! (Anaya Souza, chapter 5, in Goodley, 2000;101).

The discourse which follows is akin to mine regarding Treesha, and similarly it is mostly from people who have not got a learning disability but who comment on the effect that they feel that people with a learning disability have on their lives. Importantly though, throughout most of this thesis I will incorporate the views of people with a learning disability, including the men who were participants in this study.

Assets for love and relationships

Despite my reservations regarding some of Wolfensberger's more controversial ideas, he has written prolifically about people with a learning disability and his work has had a most positive effect upon the services for many people with a learning disability (Atherton, 2003). Particularly, he described people with a learning disability as having certain assets. Lemay (2005, cited Wolfensberger, 1988) reported that people with a learning disability have 'common assets' that are repressed by their lifestyle, which often includes oppression and poor life chances. In fact, he reports that it is because of their lack of life chances that people with a learning disability are good at, and have more ability to concentrate on, matters of the heart and relationships (Wolfensberger, 1988) - meaning, they are warm and better equipped to recognise the needs of others, having a "natural spontaneity" (Race, 2003; 213). He claims that people with a learning disability tend to react well to human attention and kindness, making them good to be around; where others have to engage their intellect, people with a learning disability engage their 'emotions more than their intellect and challenge [others'] sentimentalities' (Race, 2003; 214), which enriches friendships and help to create a positive self image (Nunkoosing and John, 1997).

The level of impairment does not appear to alter this capacity for love. Smith (2000; 72) quotes DeVinck (1989; 12), who describes the impact that his brother had on his life;

'Oliver could do absolutely nothing except breath, sleep, eat and yet he was responsible for action, love, courage and insight... This explains to a great degree why I am the type of husband, father, writer and teacher I have become'.

Below a mother discusses the love she feels for her son, who has Down's syndrome:

"..Martin needs me and every day it's a sort of compliment with some one. It makes you feel good. You rarely guessed it, because your life was so boxed in, but there's a debit and credit in every walk of life. The credit side is that there is someone who loves you and it's a lovely form of love. There's no ifs or buts about it. It's a pure love and it's lovely, you know" (Breachin and Walmsley 1989; 10).

People with a learning disability may bring more than unconditional love, as is described above.

They bring comfort to their families too, in diverse ways, just as the rest of the population do (Brechin and Walmsley 1989).

'I went into hospital to have a cyst removed. When I came out my Mam was very poorly. My brother brought my Mam a bed downstairs. She wouldn't go into hospital. So three nurses used to come every day, but she wouldn't let them touch her...after they had gone, I had to do it for her and make her bed. I used to sleep on a two seated couch and I was up six or seven times a night. The nurses told me if I didn't stop and get some sleep I'd be gone before me mother. I used to weigh ten stones and I went right down to seven stones. After my Mam died I could hear her shouting at me for a long time...' (Joyce Kershaw, chapter 5 in Goodley, 2000; 90).

Positive effects on others

When Anya Souza was born with Down's syndrome, the doctor gave her mother a pessimistic view of Anya's future. A nurse then intervened; Anya states:

'Then a nurse came up to my mother and said 'Mrs Souza your daughter will be fine, you'll get pleasure out of her'. So I did, I gave her pleasure.' (Anya Souza, Chapter 5 in Goodley, 2000; 96).

People with a learning disability have been reported to have positive effects on the lives of others which include: enrichment, teaching others to have qualities such as humility and fun and financial help (Brechin and Walmsley 1989).

Wolfensberger (2001) explored the effects that becoming an advocate for people with a learning disability has on such advocates and their families and notes that people with a learning disability may enrich others and lead them to be more patient and kind. He uses his own experience and other literature to list the benefits of being an advocate for those he terms '*protégés*' (people with a learning disability). Firstly, he describes the love and the capacity for love that people with a learning disability have. Particularly, he notes a willingness to please and a genuine concern for others. This may be part of the fun and enjoyment of being with someone with a learning disability, which Wolfensberger feels many adults have forgotten, until they are reminded of this. Being with people with a learning disability who achieve despite their disabilities, helps advocates to learn important things like determination (this sounds very like the idea of the 'super cripple' described by disabled people and others such as French and Swain (2008;27), which is a commonly derided portrayal of people with disabilities, as 'bravely' overcoming difficulties).

The advocates reported that through their work they learned that there are more important things than status, career and money and not to take the good things in their lives for granted; learning to be better people who were more accepting, patient and forgiving. Similarly, Dune (2001) reports that when working in a specialist unit with people with a learning disability unfamiliar visitors commonly have the same reactions:

'afterwards they talk primarily not about the programmes or staff, but about the great humanity of the experience of meeting the men and women who use the service. They are moved by the welcome and spontaneity, by the keen personal interest, and by the affectionate kindness and good humour. Clearly their hearts have been touched' (page 2).

Through informal interviews with colleagues, Dune (2001) listed twelve positive assets of people with a learning disability, which are similar to Wolfensberger's (1988):

'Openness, Acceptance of others, Presence, Living in the Now, A calming influence through their slower pace of life, Spontaneity and naturalness, Enthusiasm, Giving and generating loyalty and love, Trust, Helpfulness, Capacity for forgiveness, Builders of relationships and community' (Dune, 2001;4).

Wolfensberger (1988) also notes that people with a learning disability are less likely to be impressed with status or money, but rather with what he terms 'heart qualities' (Race, 2003 ; 214); judging people, not by their role, but by whether they are good or bad, whether they keep promises or are honest or dishonest. They may be more genuinely interested in how their friends are, and more apt to help people in distress, even if they are strangers. He suggests that people with a learning disability were sometimes 'remarkably detached from worldly possessions' (Race, 2003; 216), leading to a great capacity for kindness and sharing and sometimes this results in them giving away their few possessions. He believes people with a learning disability are 'remarkably trusting' towards others, even those who abuse them (Race, 2003; 215), and comments that when observed this can be 'moving and consciousness raising' (Race, 2003; 215). Of course, this may mean that they have increased vulnerability. Interestingly, Wolfensberger suggests that people with a learning disability are likely to partake of, or come closer to, unconditional love more easily than people without a learning disability:

'My mother gave me the strength to cope with life' (Downer, chapter 5 in Goodley, 2000; 82).

The various issues highlighted here are familiar to me when working with people with a learning disability, and are some of the reasons why I enjoy it so much. Additionally, despite such discourses not being popular presently, some are also highlighted in the results of this study.

The idea of difference has historically been viewed as bad, and many of the dominant discourses considered that people should be encouraged to become or be seen as normal as possible. More recently there has been a shift in the ideas about disabled people's need to fit in and the concept of difference has begun to be viewed more positively in the literature (Swain and French, 2000):

'I hate the words 'plastic surgery', totally, because we all have different faces. Why would you want to destroy it? I mean look at Michael Jackson, it's disgusting. I really hate that I really do' (Anya Souza (who has Down's syndrome), chapter 5 in Goodley, 2000; 100).

The ideas of difference are central to the discourses, and as such are key to this study. Pat Henton recalls how she does not want her learning disabled daughter to change (in Brechin and Walmsley, 1989):

"I love Vicky the way she is and wouldn't want her any different...the joy outweighs the anguish and she has been such a pleasure and delight to all of us who know and love her" (page 161).

Stories of love may be one of the ways in which we may be able to define some of the feelings that we may have for friends and relatives with a learning disability; one in which science and politics may not have so much to say and a way to begin to celebrate the different-ness that those with a learning disability can bring to our society, instead of trying to make them fit in or judge their lives by the same qualities.

As a niece and a nurse who is analysing discourse, I note the medical connotations in my description of Treasha, earlier. However, it is by those physical features, as well as her idiosyncratic behaviours that I knew her; that fascinated and enchanted me, even as a child. It is difficult to find the words to describe how you feel, I suppose, as with any relationship of love; but more so here, where there may easily be accusations of patronage. I don't know why I loved spending time with Treasha; I just knew that I did. I knew that with her there was no pretence, no games; just genuineness – you could always be accepted as yourself. I think that this is a very attractive quality and one which is recounted in the literature (Wolfensberger, 1988; Dune, 2001), and which we aspire to in nursing.

There is some charm in the eccentric behaviours which sometimes single out people with a learning disability and are the outward essence of their different-ness (Robinson, 1989). This is also true of eccentric people who do not have learning disability, for example, Quentin Crisp and more recently, Boris Johnson. Similarly, Disability Action North East (2005; 1) states:

'Maintaining diversity is as essential for humanity as it is for life as a whole. Our lives as disabled people celebrate the positive power of diversity. Our experience enriches society and these are our unique gifts to the world'.

This quotation is about the positive aspects of differences in the lives of disabled people where there is not only a world without physical barriers but without psychological barriers; a world in which society values those with a disability and celebrates the differences that they may bring.

Correspondingly Robinson (1989) reports on two articles written by West (1983; 1986) regarding her daughter. West talks passionately about her worries about normalising her daughter which may take some of her uniqueness away. Robinson reports that she describes her daughter as having little language use and understanding of social graces but also as "friendly, fun loving, gregarious, full of spontaneity" (West, 1986; 12, cited Robinson, 1989; 250). West goes on to describe a scene when her twenty two year old daughter began dancing in the centre of town when she heard a busker play. She comments:

'how could I suppress her?...The sheer joy and jubilation she conveyed must be meaningful, infectious, even important.... surely she must remind many of us of the joys we neglect to register and express in our own lives' (ibid).

Robinson reports that the ending to her article is provocative, as Hazel West suggests that her daughter's actions imply that she demands to be loved and for who she is.

In a similar vein, the following quotation is from a paper written collaboratively by colleagues and myself:

'The idea that learning disability is nothing but tragedy is a distortion of fact and a denial that people with a learning disability may live contented and valued lives. We feel honoured to have known people with a learning disability and feel that this label we give them may be a contradiction in terms; we have learned more about humanity through our work with people with a learning disability than we have with working along side those who have not. We have seen unconditional regard (something we claim to aspire to in nursing) effortlessly given. We have laughed at ourselves without embarrassment. We have seen honesty of spirit - in the depths of despair and elation - that we would not find in those with society's imposition of self awareness. We have found more joy and are often humbled by their presence of mind and honesty; their vulnerability of self; their beautiful minds.' (Inglis et al, 2002; 2).

I wrote this quotation above seven years ago and on my journey through this thesis have thought it to sound sanctimonious and patronising at times. However, I have returned to it now, not because I feel that it is academically brilliant or politically correct; but because I feel it is a true reflection of how passionately I feel about the population of people I have always worked with, a passion that began in childhood with my Aunt Treesha.

These sentiments are echoed by other writers, such as Jean Vanier, cited in Robinson (1989) who discusses the simplicity and honesty of people with a learning disability as revealing others' duplicity and hypocrisy. Their humility, he says, shows us our own pride. Furthermore, he states that people without learning disabilities build up barriers which disable them from relating to others simply and honestly. Unfortunately, such views are not popular and are criticised heavily in the literature as romantic or patronising.

The Romanticisation of Learning Disability?

Even Robinson (1989) asks if Vanier is talking romantic twaddle, or is it that the rest of society has, in fact, been corrupted. Such criticisms are often thrown at sentimental accounts and such debates are important ones to have. As I see it, there are sound arguments against the use of such 'romantic' accounts of people with a learning disability here. The first is that by generalising about people with a learning disability we use the same binary oppositions of good/bad, normal/abnormal judgements that are generally used against them; by saying that people with a learning disability are essentially good, accepting, loyal, etc. we are again stereotyping.

Furthermore, the men in this study may have offended against others and, therefore, to use such sentimental terms towards potential offenders would seem out of place. The offending behaviour is just one part of their behaviour though, and they may also be very thoughtful or humorous. Being a criminal does not discount other good qualities from co-existing. Similarly, people with a learning disability may have good qualities, but this does not make them all the same; either good or bad. They are just qualities which exist among people with a learning disability as they do in the general population, and other less impressive qualities co-exist alongside these. What is different here is that

society values only certain attributes such as beauty, intelligence and wealth, and they may not be the ones commonly described as being present in people with a learning disability – therefore, it may be necessary to emphasise other attributes to raise the value of people with a learning disability in the eyes of society.

Secondly, we should not be speaking about people with a learning disability; they should be speaking for themselves. The 'romantic' qualities are not those which tend to be reported by academics in the literature that self-advocates say about themselves. It may not be what we might like to be said about us – we may prefer terms like, intelligent, powerful, a force to be reckoned with etc. We cannot assume that people with a learning disability who cannot communicate would want these things said about them; we cannot speak on their behalf.

There are also sound arguments for using such 'romantic' accounts. Self-advocates are perhaps best placed to speak on behalf of others with a learning disability who cannot communicate easily – but they cannot know if that is what others with learning disability would say if they could, or that they would want self-advocates speaking on their behalf, either.

People with a learning disability are not a homogeneous group and, therefore, self-advocates may not be the best people to speak on behalf of others who may be less able to express how they feel. Their needs and wants may be different; they may rely upon more diverse attributes being valued. One cannot assume that people who cannot speak up for themselves would dislike the idea of being seen as a romantic figure with great capacity for love, with the ability to touch others and to change them. As with figures such as: Mother Teresa; John Lennon; Ghandi; the Dalai Lama; and Pope John Paul II. Similarly in second-wave feminism women realised that arguing that they were the same as men was redundant, gave up trying to prove that they were the same as men and accepted the differences between the sexes as valuable and something to celebrate.

It is important that positive discourses about people with a learning disability are expressed and it is not always a typical academic or political question, but one which is steeped in feelings of admiration and love. They do not only have to be qualities judged by society as generally important or powerful.

The terms used about people with a learning disability may appear to romanticise learning disability, but are similar to those expressed by the men in this study; good at understanding facial expressions, good at sensing people's moods, good at listening, loving and caring (please see results sections). The dominant discourses of academics, the disability movement and self-advocates, are just that – they are discourses. But there are other discourses which exist and are not legitimised or powerful, but which may have just as much right to be called the 'truth'.

Summary

This preface sets out my personal and professional standpoints and reasons for choice of this particular conceptual framework for the study. This thesis is not a search for the truth, or for a new or competing discourse or nursing model. This study will show, the most dominant discourses are those which are legitimised by the powerful; those which are accepted as 'the truth' by the majority of those who use them – I have set out to demonstrate how such discourses can and should be challenged. Chapter 1 offers definitions of central concepts and an overview of chapters to come.

Chapter 1 – Introduction

This analysis has been used to give a positive voice to a group of men with a learning disability living in a medium secure unit (MSU) and the staff who work with them, and also inform nursing practice. It is a retrospective discourse analysis of a local study (LS). The retrospective nature of the data gives an authentic and natural feel to the communications analysed. This lends itself well to unearthing ideology, which is the main purpose of this study. Included in the analysis are the staff and researchers who worked with the men on a facilitative action research project over twenty months. The data collected from interviews, focus groups and diaries have been analysed to extract the discourses and elicit what the subjects believe about learning disabilities and living and working in forensic settings. In addition, the discourses of the macro-models (such as the medical and social models of disability) affecting this population have been scrutinised together with national and local policy demonstrating the presence of common macro- and micro-discourses in the communications of the staff and men in the MSU.

The findings suggest that the men and the staff are very positive about their lives; they report that the men have many attributes and talents, and view having a learning disability as an advantage at times; the staff enjoy their work and good relationships with the men. Paradoxically, there are also negative discourses identified, some of which permeate from macro ideologies into policy and practice to justify the men's treatment in the MSU. A paradox is an apparently contradictory statement which may be contrary to popular opinion, but is nonetheless true (Oxford English Dictionary, 2007). Nursing practice and nurse education could learn lessons by examining the beliefs and paradoxes that underpin practice. The analysis showed that many paradoxes exist in the discourses in this setting which question the validity of official knowledge in this area, and this is essentially a Foucauldian idea. Foucault's ideas on the way that knowledge and practice may be challenged are important to this thesis.

The next section will describe the central themes of the thesis: learning disability; forensic nursing; secure forensic settings; the men; and the nature of discourse.

Learning Disability

Learning disability may be difficult to define as it means many different things to many different people¹. The term is relatively new and it replaced terminology viewed as negative, such as 'mentally handicapped' (Gates, 2003). It is a term used in both medical and professional senses, as it is endorsed by the Department of Health (DoH). It is used as a political term, where it may be seen as emphasising disability instead of ability, and has been one of the terms rejected by the People First organisation, who prefer the term 'people with learning difficulty'. Legally the term is replaced in the Mental Health Act (MHA) (1983) by 'Mental Impairment'. Impairment and disability, however, mean different things; impairment refers to the physical makeup of a person, while disability is a political term that refers to the disabling of people with impairments by a society built by and for people without impairments. Therefore, it includes notions of physical and social restrictions, power, inequality and negative attitudes.

Terms used should always be associated with the person; there are currently two accepted ways of expressing this. The first is to refer to someone as a 'person/people with a learning disability'; therefore, placing the person, before the learning disability. The second is more political and a term preferred by self advocacy groups such as The Lawnmowers (2005) and is 'learning disabled people'. Much like the general disability movement, this term is used to take the emphasis from the person and place the disability back in the lap of society; they are disabled by society (Docherty *et al*, 2005).

Learning disability is difficult to define². It is not just an intellectual disability, and may have a global affect; it can mean people have social difficulties, affect communication and behaviour, and be associated with certain physical, behavioural or mental health needs which are not effectively met (MENCAP, 2004; UKLDCNN, 2005; Michael, 2008). Not all the health issues affecting people with a learning disability are related to their impairment, but may be associated

¹ It is, however, defined in the literature and in legislation (for example DoH, 2001) referred to later.

² Indeed literature and data from this study confirm this.

with the way that they are treated because of their impairment. The issue here is that one label attempts to cover all aspects of a person's life, which can range from intellectual needs to physical needs and the label changes depending upon who is defining it and for what purpose.

Learning disability is a simplistic label for a complex concept, if indeed it is a single concept, and simplistic definitions and labels are inadequate. This may compound the problems associated with the categorisation of people generally, which have historically been viewed as negative (Oliver, 1991).

Additionally, a difficulty lies in that people with a learning disability are not a homogeneous group. They have differing needs and wants, and different levels of ability. For example people may be physically or sensorily impaired, as well as having a learning disability, and requiring twenty-four-hour support; though most people with a learning disability require little support to get on effectively with their everyday lives (MENCAP, 2004; UKLDCNN, 2005).

This apparent group of people with a vast range of abilities and wishes is classified under one label, meaning that particular discourses and ideologies are applied to all, despite their individual wants and needs. People with a learning disability are not only disabled; they are also men, or women, Catholics, Muslims, white, black, drink tea, prefer coffee. They probably have more in common with others in their culture, peer group and families than they have with each other by virtue of them each having a learning impairment. Their disability may not be central to their identity, and there are very sound reasons why this may make good sense. The terms used to define people with a learning disability are commonly negative, they are devalued in society, generally treated with fear, scorn or pity and are most often described in negative language; a language of deficits (Wolfensberger, 1998; Swain and French, 2008).

The negativity associated with learning disability may be intensified when people have a forensic history, as this confirms the myths associated with criminality and justifies the fear and scorn connected to this population. Incredibly, so negative is the label of learning disability to some people with forensic histories that the label of criminal may be seen as more positive than the

label of having a learning disability; as some people with a learning disability in high secure environments may prefer to be known by their offence history (Inglis *et al*, 2004).

Rarely are they described in positive ways. There are, however, very positive parts of having a learning disability, and of being with people with a learning disability – otherwise friends, relatives, carers and nurses would not enjoy being with them as much as they do (Swain and French, 2000; Wolfensberger, 2001; Inglis *et al*, 2002). For example, people with a learning disability have been described as capable, loyal and enthusiastic employees who make other workers enjoy work more (Down's Syndrome Association, 2007; Personnel Today, 2007). They are also described as people who add something positive to society's diversity and as people who have good insight and a large capacity for sharing love and inspiring others (Brechin and Walmsley, 1989; Swain and French, 2000; Smith, 2000;). The terms used will become a significant part of this study, as they take an important place in the discourses surrounding learning disabilities. For the purposes of this introductory chapter, however, it is sufficient to state that most terms are not adequate, or always necessary, and commonly they share negative and sometimes medical connotations.

Throughout this study the accepted term of learning disability will be used as this is the most common and conventional term used in the National Health Service (NHS) and the local services in which this study is located. The men with learning disability who have taken part in this study, will be generally referred to as "the men" and not as patients, which is their current status in the forensic setting in which they live.

The chapter will now turn to defining secure settings.

Issues in Nursing in Secure/Forensic Environments

Primarily nurses working within secure settings for people with a learning disability are registered nurses for people with a learning disability (RNLDs). Some nurses in the health sector are called Forensic Nurses, which itself is a term which causes confusion. Forensic is a word that is connected to the court and in the health sector in the UK this word tends to imply that they are nurses working with Mentally Disordered Offenders (MDOs). However, many of the patients within these secure settings have not offended and have not been in contact with the criminal justice system (CJS). Some people are placed in secure environments because of the danger they present to themselves or to others³.

In England, nurses working in secure environments have a dual role which causes some confusion; they care for the patient as a nurse in a comforting role, but they also have additional roles of security and, as such, become part of the system which incarcerates the patients. There are problems with the relative recentness of the development of forensic practice, a lack of specific evidence base and issues of stigma and security which create difficulties in this practice area and are primed for practice development.

Practice Development

Practice development was defined by McCormack and Garbett in 2000 (and 2003) as something which improves the effectiveness of patient-centred care through a continuous process. This is achieved through the development of knowledge and skills in an autonomous but systematic way, reflecting the views of service providers and users, and which includes education and research into practice. One of the first and most influential parts of practice development is to raise awareness amongst colleagues, organisations and service users. This thesis will give a voice to the men and the staff regarding the ideologies which affect so much of their lives and expectations and hold the

³ In this thesis the terms secure setting/environment and forensic setting/environment will be used interchangeably.

opportunity to impact upon literature and, ultimately, on the lives of people like the men. Research has been shown in the literature to be ineffective in changing practice as nursing staff are shown not really to understand research and its importance to practice development (Hundley *et al*, 2000; Parahoo, 1998). Yet practice development is important to the patient, the nurse and the profession, and is often seen as something 'extra' to our work. We know we have to deliver care but are not always aware that we have to develop it. Patient tasks are often viewed as the only way to do a good job, whereas in fact reading and research develops the practitioner professionally and enhances patient care (Clarke and Procter, 1999).

As a researcher outside of practice, any innovations may be viewed as being imposed from above; when carrying out research without the practice area one stands accused of being outside of organisational, practice and patient issues - and whilst standing within practice one is not viewed as an objective researcher (McCormack and Garbett, 2003). This, according to Clarke and Procter (1999), generates a challenge – participants in their study discussed tensions which existed in order for change to occur. In the management of diversity and uncertainty, they firstly described how development of practice was quite ambiguous, in that it was often difficult to define exactly what had changed and when. Clarke and Procter (1999) argue that it is this very component of testing out our innovations and practices which creates the knowledge base to develop practice.

Clarke and Procter (1999) suggest that research in practice is intrinsically different to that of academic research; the first attempts to answer questions regarding their nursing role, and the second tries to generate new knowledge. This study will influence practice through questioning the ideologies which underpin forensic nursing practice increasing knowledge in this specialist arena; therefore it fits into both definitions.

Practice development encompasses the carrying out of research by practitioners and patients, and does not always involve the use of traditional research methods. It could involve the use of more reflexive methods which allow for the movement between practice and theory. One of the most well known forms of this in recent years is action research, which the data in this thesis is based upon

(Waterman *et al*; 1995). This thesis may potentially influence the patient, carer, practitioner and organisational spheres and these are explored in the final chapter.

People with Learning Disabilities: the Forensic Population

'This group of people is easily managed in the forensic care system and does not require high staffing ratios, but they are likely to require care in terms of decades rather than years.' (Musker, 2001; 163)

The people with a learning disability in forensic settings have a wide range of needs and share some characteristics. They are commonly young, males, have a mild to moderate learning disability, are very streetwise, in their early twenties with challenging behaviour and/or psychiatric history, have reduced social skills and familial, social and financial difficulties, psychopathy and criminal behaviour (Day, 1994; Brown and Stein, 1997 ; Seaward and Rees, 2001;). They are more likely to have higher rates of psychopathology, with little evidence of efficacy of interventions (Barron *et al*, 2004). They share characteristics with the rest of the offending population as they are younger rather than older, and male rather than female. However, unlike the rest of the prison population, the most common form of behaviour which results in their forensic history is aggression, followed by sexual behaviour and then self harm (Seaward and Rees, 2001).

There are associations and certain myths surrounding links between learning disability and criminality (Lindsay and Taylor, 2005) and the crimes for which people with a learning disability are held seem to confirm them. Sex offenders appear to be over-represented in the population of people with a learning disability who offend (Day, 1994), though this may be no reflection on the prevalence of offenders with a learning disability. Studies have shown that the overall prevalence of offenders is similar or lower in people with a learning disability when compared to the general population, and their offences tend to be less violent than their non-disabled counterparts. Despite this they may be held for long periods, many miles from home (Day, 1994; Brown and Stein, 1997; Musker, 2001).

There is evidence that people with a learning disability are less criminal than the general population and their sexual crimes are less violent and less likely to involve penetration, but they are more likely to be given a custodial sentence than the rest of the population for such crimes (Wilson and Brewer,

1992; Brown *et al*, 1995). There are many studies with different rates of prevalence, as the data are collected at various stages of the criminal justice system and use different criteria for learning disability – none of which are adequate to make a formal diagnosis (Beail, 2004). The World Health Organisation (1992) found only 1 percent of people with a learning disability offended using the ICD-10⁴, but McBrien (2003) reviewed other studies and suggested the prevalence to be between 2 percent and 9.7 percent and between 1 percent and 10 percent (Prison Reform Trust (PRT), 2007b).

Learning disabilities have long been associated with criminality yet the true figures illustrating the relationship between the two are unknown (Lindsay and Taylor, 2005). A Longitudinal Study in Sweden found that learning disabled men were three times more likely to offend and five times more likely to have a violent conviction than non-disabled controls⁵. Studies have shown that within conviction and detainment rates for people with a learning disability around half of their admissions are for violent crimes, with medical and nursing staff making up the majority of their victims (Maden *et al*, 1995; Woods and Mason, 1998). However, people with a learning disability are at much greater risk of becoming victims of crime than becoming criminals. Despite laws which aim to protect people with a learning disability from exploitation, they are at greater risk of physical and sexual assault, robbery, theft and burglary than the rest of the population (Wilson and Brewer, 1992; Brown *et al*, 1995; Quarmby, 2008). Whether the conviction rates relate to prevalence is unknown; people with a learning disability may be more likely to gain convictions because they are learning disabled as they are treated differently in the CJS from the outset.

⁴ The classification system commonly used for diagnosis in England -The International Classification of Diseases criteria - 10 (WHO, 1992). However, the ICD is revised regularly and different versions exist.

⁵ In learning disabled women the study showed that they were four times more likely to have convictions and 25 times more likely to be convicted of violent crimes than non-disabled controls. However, women in forensic services are shown to be much more psychiatrically disturbed than their male counterparts (Hodgins, 1992).

People with a learning disability that Come Into Contact with the CJS

From first contact with the CJS, people with a learning disability may be treated in a discrete way from the general population because they are disabled - as the Criminal Procedure (Insanity) Act 1964 states:

"Mental disability (as in the MHA) on the part of the defendant may affect the outcome of a case in three ways:"

- Mental disability at committal may mean that the person is "unfit to be tried"
- Mental disability at the time of the offence may give rise to the defence of insanity (alternatively, diminished responsibility in a murder case)
- Mental disability at the time of conviction may require hospital admission under the remit of the MHA (1983), sec 37 sub section 1 (Card *et al*, 2006; 719).

This different treatment is sometimes viewed as to their advantage, and sometimes to their detriment; as they are able to be treated differently through legislation (namely the MHA); however, they may be considered more vulnerable⁶.

The vulnerability continues when people with a learning disability are held in custody. They may be more vulnerable to bullying and abuse than others and are entitled to protection through legislation (PACE, 1984). The Reed Report (DoH, 1992) stated that offenders with mental disorder should be diverted from prison to health care – whether that is in a community or an institutional setting.

Notwithstanding, The No One Knows Report (Prison Reform Trust, 2007a) surveyed the prison population and found that there are almost 6,000 men, women and children with learning disability in prisons. A further quarter of the prison population has a borderline learning disability and the prison service has no routine screening and prison staff untrained for the people with a learning disability in their care. Liverpool University carried out this research at the request of local NHS Commissioners in three prisons and young offender institutions and found that the average IQ in each was well below 90 (people with IQ scores of 90 can be considered as having a borderline learning disability and be treated in specialist services, if they have other specific needs) and blame genetic and environmental causes such as poor upbringing, schooling, mental health, drug use and head injury.

⁶ For a detailed account of differential treatment of people with a learning disability in the CJS please see Appendix 1.

'Being in prison is frightening. People shout a lot. It's noisy. You don't know what's happening to you. They do things to you and take over. People who work in prison need to know how to support people with learning difficulties and disabilities' (Prison Reform Trust, 2007a; 1)

They conclude that the prison regime should include education, health and social care and rehabilitation. The UKCC commissioned a project to provide an overview of nursing in secure environments⁷ and some of the findings are included in the review in Appendix 1 which details security available at high, medium and low levels.

The Men and the MSU

The MSU is in a hospital which is a specialist provider of disability services and with a commitment to research and development. The key participants in this study are a group of seven men with complex needs and the staff members who work with them.

The MSU is an imposing but modern building which was specifically designed and relies upon physical security being provided by the design of the building. It comprises four houses (referred to as 'flats' or 'units') for a total of thirty men, arranged around a central courtyard. Included in the design are en-suite single bedrooms, occupational areas such as educational rooms and a very large gymnasium. Outside is a fenced garden for the men to attend gardening work. Treatment is based upon patient-centred individual treatment plans directed by psychiatrists with a named nurse system. The mean age on admission is 26 years and almost 75 percent of the men are between 20-40 years old. The one public entrance is of "air locked" design with security staff at a central desk. All of the staff carry alarms and are tagged, so that they may be detected wherever they are in the MSU, in case of an emergency. The tags open doors, and no keys are carried. The staff dress smartly, but conservatively as a role model to the men.

Ninety three percent of the men have a criminal record. The men held in the MSU have a range of diagnoses in addition to their learning disability. For example, 13 percent are diagnosed as schizophrenia/paranoid and 13 percent have a diagnosis of depression/post traumatic stress disorder. Sixty percent of the men held here have a history of alcohol/substance abuse, and for most of the

⁷ In 1998 with The University of Central Lancashire (UCLAN) to explore forensic settings.

men, despite MSUs being considered a short term placement, this becomes a relatively long placement with a mean length of stay of 3.5 years, compared to the eighteen month stay that is recommended (UKCC and UCLAN, 1999; Cook and Inglis, 2006).

Typically, 50 percent of forensic in-patients could have a diagnosis of personality disorder (De Girolamo and Dotto, 2000), but other prevalence rates put this at 22-27 percent as diagnosis is difficult, especially in people with a learning disability (Deb *et al*, 2001). Similar to other psychiatric disorders common in these settings, personality disorder is caused by a combination of genetic, organic and behavioural factors, but central to the cause is the poor and dysfunctional familial background which is common to the men in the MSU (Jarrett, 2006).

The symptoms include irregular emotion manifested as mood swings and/or abnormal behaviour, which is often treatment resistant and which provoke negative attitudes in those around them (Dew, 2007; Filer, 2005).

The Men

There are five men currently taking part in the study. At the beginning of the LS they were all being held in a Medium Secure Unit for men with learning disabilities in the North of England. In order to build an accurate picture of the men, their personalities and abilities which contributed to the study, I will give a brief introduction to each using pseudonyms to protect their identity.

Matthew is a man in his thirties who is very thoughtful, with a highly developed sense of self awareness. He appears very considered in his approach to anything he takes part in. Matthew has been very enthusiastic in his approach to the LS and has enrolled in a local university to enable him to be accredited for his hard work. He has since taken part in a pilot study where he not only joined in as a researcher, but also as a facilitator to help other men with a learning disability learn about research. He took the lead in many respects to enable the men's learning outside of the workshops. He is currently assisting with the dissemination of data from the LS. Since the beginning of the project, Matthew has been moved to a lower degree of security.

Mark is a man in his early thirties, who presents as very enthusiastic and engaged. He gets along well with others with his easy manners and has worked hard throughout the LS. Mark has also enrolled at a local university and has been accredited for his hard work. Mark has continued to support the researchers during the pilot study and been engaged as a facilitator for other men with a learning disability to learn about research and throughout the dissemination process.

Luke is a handsome and engaging young man in his late twenties, with exceptional communication skills. He is fully engaged in the LS and has made very valuable contributions. Luke also enrolled at the local university and his work was accredited. Luke has continued to enthuse throughout the pilot study and has been engaged in facilitating other men with a learning disability to learn about research. He too continues to contribute to the dissemination of the LS. He has now been moved to a lower level of security.

John is a very quiet young man in his early twenties who, at the beginning of the LS, had only recently been admitted to the secure unit. He is also very considered in his approach, and has made some useful contributions to the LS, especially as he began to build relationships with the rest of the group and developed his confidence. His work has been accredited, he has contributed to the pilot study and has also presented at a conference. He has now been moved to a lower level of security.

Paul is a man in his late forties with a highly developed sense of humour who is very literate. Despite this Paul has been unable fully to engage in the project as his level of understanding and powers of concentration do not match his enjoyment of his participation in the LS. He has, though, made some valuable contributions and made others' contact with him very enjoyable. Paul chose not to have his work accredited but also contributed to the dissemination of the project.

The other two men, who have withdrawn, will be known as Joseph and Jacob.

Joseph is a quiet and articulate man who enjoyed taking part, but was transferred back to prison during the study. He contributed well to the project and his contributions are reported here.

Jacob is a tall, well-built, quiet man who found it difficult to articulate what he wanted to say. He withdrew from the project as he wanted to concentrate on other things. After careful discussion and consideration Jacob decided to withdraw permission for the use of any of his quotations in my doctoral thesis and they have duly been removed.

People living in secure settings and the nurses working with them are subject to discourses which are the subject of this thesis. The concept of discourse will now be introduced as it is central to this study.

Discourse

Discourse is more than a conversation, it is a group of ideas which can be seen in the text we use personally and in the wider society through institutional language (Horsfall and Cleary, 2000). It is the way the world and its problems are articulated, and imposes some homogeneity of ideas upon us, the perspectives on those problems and, perhaps most importantly, the solutions to those problems (Horsfall and Cleary, 2000; Thompson, 1997). Therefore, the importance of discourse cannot be over-estimated where people with a learning disability are concerned. This study takes a Foucauldian view of discourse and its effects. Here, power is embedded in discourse, which tells us what to believe and how to behave. The whole of Chapter 2 is dedicated to such ideas.

Primarily, the discourses relevant to this thesis relate to understandings of how the men are perceived and how forensic practice is viewed. We find these in commonly expressed ideas which are referred to as repertoires (Marshall and Raabe, 1993). Studying the repertoires in the discourse reveals paradoxes which signpost difficulties with the discourses we use. For example, the men in the study were described as dangerous and vulnerable - these two ideas appear opposing, yet commonly co-exist in the minds of the participants in the study. What is interesting is finding out how this co-existence is defensible, or what treatment it justifies. Examinations of such paradoxes expose the rationalizations that people make for treatment of the men in secure settings. These are referred to as practical ideologies which, when studied, disclose the beliefs which underpin discourse (Gill, 1993).

This study exposed many positive elements of working in this environment and affirmative aspects of the men and their lived experience which begin to develop new constructive discourses about forensic practice. This introduction continues by leading the reader through summaries of the chapters to come to appreciate the context of the thesis and ends by examining why the thesis is significant and placing it in a social and political context.

Overview of Chapters

Chapter Two explores Foucauldian methods of analysing knowledge, discourse and power, and I draw upon literature and Foucault's own writings to describe specifically how and why Foucault explores subjects in his original way. In this chapter, discourse is described as not merely representing, but also creating the world around us through the production of knowledge. Foucault used criticism to expose and challenge official kinds of knowledge/truth, as in this truth lies power. He believes that power lies all around us, and it gives us rules to follow and shows us how to behave and what to believe. The chapter ends with explanations of relevant Foucauldian analysis of madness, disciplinary practices and sexuality, to demonstrate how discourses similar to those of learning disability may be constructed, reproduced, used to control behaviour and, importantly, how they may be challenged.

The next two chapters trace historical and current discourses relative to this study, encapsulating the macro models, culture and policy to give a socio-political overview and place the study in context. Chapter Three historically explores the discourses associated with learning disability and nursing (RNLD); historical and current discourses are surveyed which represent central macro discourses for the purposes of this thesis and demonstrate how different discourses produce alternative treatment of people with a learning disability. This disabled identity is explored with reference to creating a positive group identity in forensic services which magnify the associated negative discourses. The chapter closes with examples of positive writings about learning disabilities, by people with a learning disability, to acknowledge and develop positive discourses of learning disability.

Chapter Four develops the exploration of discourses specifically relating to learning disabilities and forensic nursing practice. It begins by examining the effects of policy which reflects society's beliefs, attitudes and values of people with a learning disability including myths, stigma and negative values. The chapter continues by examining national and local policies and their influence on the culture of the organisation, and how such culture may influence policy. The focus of the chapter then moves on to an exploration of nursing roles and skills and the importance of the therapeutic relationship. This relationship contains many paradoxes, but central to the role of the nurse is the security-therapy paradox, which relates to the nurse having both a caring and a security role. These conflicting roles are confusing for both nurses and patients in this setting and some roles may be in direct opposition to that which people might consider as positive nursing attributes. Such positive nursing attributes include: trust, warmth, caring, a non-judgemental attitude and others that are related to the concept of "the good nurse", which appear contradictory and difficult to establish in forensic settings.

Chapter Five is concerned with the methodology and methods of the study. The Local Study (LS) from which the retrospective data of this study were obtained is briefly explained and an overview illustrated. The chapter then turns to discourse analysis particularly employed in this thesis. Critical discourse analysis and its critiques are explored and the trustworthiness of the data is examined through a description of the research process, methods of data collection and analysis. The key themes emerged from the data through several rounds of critical discourse analysis based upon methods recommended by Potter and Wetherell, 1987, Wood and Kroger, 2000 and particularly, Burman and Parker, 1993.

Chapter Six begins with an introduction to the results and discussion sections. It explains the ways in which the following three chapters are laid out. It discusses the ways in which learning disability and the men are represented in the data. It examines paradoxes relating to people with a learning disability being viewed as the same and as different to others and its implications for their treatment. In particular, it examines the fundamental beliefs upon which practice is based and exposes inconsistencies in beliefs and contradictions in justifications, thus unearthing the 'material of ideology' and the possible functions of discourses. The contradictions found here are

not unique, but this setting has not been explored in this way before, and the paradoxes exposed enable nursing and medical knowledge to be questioned as to its ability to justify current treatment. Central to this thesis are the positive discourses about the men which are crucial to the implications for this thesis. The men are viewed as people with abilities and talents, as well as positive personal attributes; such data enable the development of more positive discourses about this population.

Chapter Seven is the largest of the chapters and explores ways in which the MSU is experienced by the men and the staff. It exposes positive and negative aspects of detainment for the men and examines the concept of security and its necessity in such settings. Key to this analysis is the *exposé* of discourses of disciplinary practices present and their functions. A central theme is one of choice and rights which are withheld in these settings and the ideologies underpinning, and justifications for, such infringements.

Similarly, the therapeutic relationship is examined through the discourses of the staff and the men in Chapter Eight as, here, a warm and supportive relationship is exposed paradoxically, in an atmosphere of suspicion and security. The fundamental beliefs about the men's lack of ability are at odds with the level of security and scrutiny justified by policy and staff.

The final chapter is concerned with the conclusions, implications and recommendations emerging from the study which may affect practice and nurse education and training. It critically assesses nursing practice in such settings operating across three domains; critical analysis, critical action and critical reflexivity (Barnett, 1997;90-102). It ends with personal reflections on the thesis.

Study Aims

This study has several main aims which are to:

1. take a critical and a post-modern approach to investigating given “truths” about the positives of having a learning disability, men with a learning disability who offend, and forensic nursing.
2. apply critical discourse analysis to examine micro discourses and the macro models associated with learning disability, national and local policy, nursing and disability models, giving a socio-political overview.
3. combine the discourse analysis of aims 1 and 2 to expose discourse, repertoires, paradoxes and practical ideologies which justify treatment on the MSU and expose the ideologies and beliefs about learning disability in this setting.

There are few studies regarding forensic learning disability practice. This study will add to the small amount of specific literature and the findings will be used to question and inform practice and nurse education in this specialist practice area.

Summary

This chapter offered an overview of the thesis. It defined terms and introduced the reader to the main concepts of the study. The next chapter sets up the broad methodological stance by reviewing Foucault’s work and its relevance to this thesis.

Chapter 2 – Challenging Dominant Discourse: A Foucauldian Perspective

The central theme of this thesis is the development and use of discourse in forensic practice which affects people with a learning disability. In the study of discourse it is inevitable that the ideas of Foucault be sought, especially when the thesis concerns people who are categorised and about whom specialist 'forensic' knowledge has emerged, as Foucault's methods have been used successfully to criticise similar social issues. Foucault's work is of importance to this thesis as it offers both a methodological base for challenging truths about people with a learning disability living in forensic settings, and also ways to challenge accepted forensic knowledge and practice through exploring the macro and micro discourses surrounding it.

This chapter will explain how Foucault approached his analysis and, in particular, the concepts of knowledge, power and discourse. Notably it leads to a brief discussion of how the thesis will use certain types of discourse, repertoires and practical ideologies to unearth ideologies surrounding forensic practice. Foucault believed that discourse creates knowledge and in knowledge lies power. Therefore, those who create and maintain discourse create and maintain knowledge and power. This is similar to the way that discourses surrounding people with a learning disability create knowledge and myths which enable people to separate them and treat them differently to others.

I will show how he used criticism to unearth subjugated knowledge (which is unofficial or hidden knowledge) and show alternatives to official and scientific accounts of the truth that we generally accept and therefore challenge the power that it holds. For example, the knowledge that people with a learning disability are just like everyone else, with the same feelings, wants and needs as everyone else, challenges the view that they are different and should be treated differently to others. The chapter continues with examples of discourse related to learning disability and forensic practice that are used to demonstrate the construction and use of discourse and reveal ways to challenge such constructions. Whilst Foucault is viewed as a popular figure to follow, his work is not without criticism and some of these are also addressed.

Foucault re-thought three central ideas in the history of ideas according to McHoul and Grace, (1995; 1-25); knowledge⁸, discourse, and power. His ideas were political in nature and he sought ways of thinking outside of those traditionally used in his time and his methods reflect this (McHoul and Grace, 1995; 1-25).

Foucault's Histories

Foucault wrote histories of madness, clinical medicine, social science, prisons and sexuality through methods he termed archaeology and genealogy⁹. Archaeology was developed from concepts, therefore is not concerned with individuals but with the linguistic structures of the fields that individuals operate within. Yet typical histories are still required and its weakness lies in the de-centering of the subject and, therefore, its abstraction from the intellectual lives of the subjects or thinkers (Gutting, 2003; 1-28; Flynn, 2003). To separate the individual from the idea was key for Foucault, as he believed it was not about the genius of particular writers, but about the ideas and concepts of the time that the writers thought in that mattered.

Genealogy is a particular way to study a history of the present - it damages grand narratives through questioning the inevitability of the development of practices and institutions in particular ways - by showing alternatives. It has been criticised as, in its narrowest sense, it may be too narrow to operate at the macro level, and therefore, misses some of the relevant material for analysis (*ibid*). However, Foucault used several different methods to uncover alternative ways of thinking about our world, thus calling into question this criticism of his methods (Dreyfus and Rabinow, 1983). These methods are important for this thesis which challenges present practice through analysing discourse. Gutting (2003; 7) traced Foucault's work through four dimensions, the histories of ideas; of concepts; of the present; and of experience (Gutting, 2003; 49-73).

⁸ Knowledge was the focus of the history of ideas.

⁹ Genealogy is concerned with how we understand the present and questions the necessity of the practices turning out this way, whereas archaeology is more interested in the concepts which structure our reality.

History of Ideas

In his histories of ideas, Foucault ¹⁰ showed that ideas were not created through a universal spirit or logical route but were constructed in particular ways as 'truths'. These texts proposed that there was a spirit of "progress of universal reason" where every historical change was a continuance, a progression of the "universal reason" towards the truth (McHoul and Grace, 1995; 8). In contrast, Jean-Paul Sartre and existentialist thought postulated that historical change occurred not because of a spirit of progress, but because of the ability of humans to create new ideas – i.e. they held a progressivist view (McHoul and Grace, 1995; 1-25). These two opposing views of ideological change were challenged, especially by Foucault.

Linguistics had its own crisis and from it came ideas that were political in origin and known as the linguistic turn. Here language was reduced to ideas, concepts and imprints and discourse and language became more than a representation of reality with discourse and discursive relations being studied in their own right; they then both became critical and political.

Foucault believed that the development of phenomenology in France questioned rational thought and the ways in which it had developed (Goldhammer, 1996). Firstly Canguilhem (who trained as a doctor in medicine and philosophy), challenged the continuist nature of biological ideas and claimed that they could not be linked with ideological change, but were quite ad hoc; they did not move logically towards universal reason.' *Foucault's introduction to Canguilhem's most important work has the effect of making Canguilhem out to be Foucault's precursor.*' (Goldhammer, 1979; 1). Ironically, it was Canguilhem that first suggested that just because one thinkers work came after another is no proof that such work was an essential precursor to another's '*His [Foucault's] implicit designation of Canguilhem as a precursor of himself ignores Canguilhem's critique of the concept of precursor.*' (Goldhammer, 1996; 1).

Canguilhem questioned the positivist views of science, especially psychology as a science itself, and their separation of fact and value in science; he separated the known object (we, as objects of knowledge) and the knowing subject (we, as organisms that also know), and suggested that this was the error of positivist science, something which Foucault later built upon to recognise that the '*world is a theatre of living beings.. the scientist' method of research [is] at the expense or loss of the object*'

¹⁰ The history of ideas was well established in France at the time of Foucault so it was integrated into his education.

(Roberts, 2000; 693). Through this, Foucault corrected the errors of positivist views of science in a postmodern way by enfolded the subject and the object in his enquiries enabling a critical view, i.e. enabled the use of Canguilhem's value in science (Roberts, 2000).

Foucault rejected the Hegelian idea that history would lead eventually and progressively towards knowledge and truth and replaced such ideas of new theories being seen as different and not always superior. Such clusters of theories were believed to come together to produce objects of science – sometimes called constructivism (a Nietzschean idea) (McHoul & Grace, 1995; 1-25).

The natural sciences as well as the social sciences began to be thought of as fragmented, the history of ideas had changed and new ways of thinking about scientific knowledge emerged in which it was no longer automatically accepted as the single truth (*ibid*).

This is particularly pertinent in today's nursing philosophy of evidence-based practice which relies upon research findings to justify the treatment of people with a learning disability held in hospitals.

Foucault's history of concepts showed that concepts are developed by influences on thinkers of that time and the discourses available to them. Foucault analysed individual thinkers and their influences on one another and believed that the context and space in which the thinker thinks has a great influence on the thinker. He analysed the past to understand the problems of the present and show alternatives to the way things are.

Foucault showed the present *status quo* as neither inevitable, nor current practices the only solution to the past: institutionalising the mentally ill is not the only way to help them, similarly with detaining offenders. Foucault shows that madness has been seen historically as a moral fault and more recently madness is viewed as an illness; both are social constructs, neither has any more claim to the truth than the other (Gutting, 2003; 49-73). Similarly, histories of experience occur in most of Foucault's histories which illustrate the categories that structure the way in which people, at certain times in history, perceive and think about objects like physical illness or criminality. He used discourse and behaviour to define the 'mentality' of a specific age.

One of the main criticisms aimed at Foucault is that he did not produce theory; he just problematised others' theories (as discussed in Sawicki, 2003). The non-production of theory was central to Foucault

though, he did not wish to tell others what to think, and instead he unearthed alternatives so that readers would make up their own minds.

Importantly, Foucault's methodology showed that scientific knowledge was not automatically viewed as the single 'truth' and that the way in which an age thinks is related to the discourse and knowledge of the day. He illustrated that present practice was not inevitable or necessarily an improvement on previous practice, and used criticism to challenge current knowledge - as if we know how knowledge is made, then we can un-make it. Similarly, this study examines the historic and present discourses and the practices which they justify. As the chapters unfold I hope to show that, as with Foucault's studies, there are no single or inevitable improvements in practices which exist today, but paradoxes and multiple truths about forensic practice for men with a learning disability.

Knowledge

Foucault traced the systems of thought that emerged which he called 'discursive formations' (McHoul and Grace, 1995; 11), and believed that the author function¹¹ was crucial. It is important to check the discursive and epistemic conditions, as in doing so we see how the knowledge is made and we can see exactly what it is, not what it claims to be. If we know how knowledge is made, it can be unmade. Using the eugenics discourse as an example, examining those theories, who they served and knowing how they came about means that we can argue against them – deconstruct them and challenge them (McHoul and Grace, 1995; 1-25).

My ideological base is stated from the beginning of this study in the Preface; one which is lodged deeply in personal beliefs and nursing humanistic philosophy. One of the ways in which particular discourses become powerful is through knowledge or 'truths' being buried by the powerful whilst promoting their own discourse. Foucault termed this hidden truth 'subjugated knowledge'.

Throughout this study I hope to offer several truths and unearth subjugated knowledge about forensic practice to enlighten the reader to alternatives from accepted practice which is evidence-based. One important issue is the question of who decides what evidence is accepted as good evidence to base

¹¹ The author function is the discursive and epistemic conditions (relationship between researcher and knowledge) which are necessary before the author can be assigned to an individual or text.

practice upon, and this changes historically depending upon the dominant discourses and knowledge of the day.

Subjugated Knowledge

In his explanation of madness and sexuality Foucault actively sought to expose previously '*subjugated knowledge*' (McHoul and Grace, 1995; 16)¹². He showed that '*it is through the reappearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work*' (Foucault, 1980; 81-82 cited McHoul and Grace, 1995; 16). His aim was to unearth hidden truths - all of the truths, not only those which are dominant. Working this way exposes how official knowledge leads people to the 'correct' ways of thinking and acting, and discounts other forms of knowledge that differ from the official line. They do this, for example, by dividing the normal from the abnormal person and the good from the bad citizen (McHoul and Grace, 1995; 1-25). What counts as the truth, therefore, depends upon certain techniques – institutional and discursive practices – and Foucault questioned the value of these techniques.

Feminist writers share this way of viewing the world as important; the uncovering of forms of buried knowledge by dominant ideologies – in the case of feminists however, it is the ideologies of women that require unearthing (Sawicki, 2003). Feminist writers accuse Foucault of assuming that by studying men, he is studying the whole culture - in fairness though, the majority of historical writings remain male oriented; making it difficult for Foucault to avoid the study of men (Sawicki, 2003).

He did not say that there is no truth, but that there are many truths at any given time - how and why one of these comes to dominate at any time in history is of interest. Therefore, instead of looking for the truth, Foucault examines this continuous search for the truth as the subject of critical analysis and description.

¹² Subjugated knowledge according to Foucault means "*Historical contents which have been buried...are present but disguised...and which criticism...has been able to reveal*", and knowledge that has been viewed as inadequate which is ignored and perceived as inferior to scientific knowledge.

Discourse and Truth

Foucault studied how ideas of language had emerged (through his publication: *The Order of Things*, 1966) and examined the archaeology of the human sciences, and how we began to think of language as not merely the representation or system of how we expressed ourselves, but also as a structure of representation. During this he moved beyond exploring what had been, to discover and account for this concept of discourse in which the world is not merely represented, but can also be created (McHoul and Grace, 1995; 26-56).

Wittgenstein originally proposed that through applying mathematical logic to language, the world could be understood. He believed that philosophical problems could be avoided through a methodology which analysed the logic of language; since language, thought and reality have a common structure. He later retracted this proposition and earlier presumptions - since logical analysis is too precise to be useful to the analysis of ordinary language; words, at best, bear only a passing resemblance to one another in their various usage, whilst expressing similar thoughts (Marshall, 2001).

Unlike Heidegger, he believed in the importance of understanding, not of interpretation. As if we interpret language then, we may require an interpretation of such an interpretation – *ad infinitum* (Patterson, 2006). Understanding is something else altogether; it is the application of the same actions to show understanding as Patterson States: '*all human practices are grounded in understanding exhibited in action*' (page 138). We show that we understand by the actions we take after the utterance, or by following the rule, or by following the signs etc. Wittgenstein, therefore believed that the meaning of words was evident in their use. So, the philosophical problems which arise from the misuse of language may be solved through attending to the use of ordinary language instead of the logical analysis of formal language. Wittgenstein termed such use of language, in which we all know the rules which govern their use and we all partake of: language *games*. These games are socially sanctioned and are similar in form to Foucault's discursive practices (Flynn, 2003). They show how language is central to how we understand and create the world around us

Discourses do not represent the truth, but merely contain the subject of their own discourse within the supreme discourses of science. This is the power of one discourse in relation to other discourses –

power is a discursive relation. Foucault used his unique explanations to challenge official types of knowledge and official versions of the 'truth'; which is important if one views power and its production as lying in knowledge. Knowledge and power enable the powerful to construct and discipline society. This process is central to the production of received knowledge, and therefore to the production and sustenance of power.

Discourse works through institutions to show people how to make sense of the world and it contains many accepted truth in the search for the "ultimate truth". But these truths are dependent upon the institutional and discursive practice¹³ which tells people what is true and untrue. It exists, in particular, in institutions such as education, science, law and government – called 'games of truth' which are used by institutions to tell people which truth is valid or invalid (Danaher, *et al*, 2006;13-29). Foucault denied that any truth or knowledge is justified and that all truth is created by power.

Foucault rails against truths and cause-and-effect explanations, yet they became implicit in his histories of madness and others, for example it is apparent in his view that the confinement of the poor in the eighteenth century was driven by economics. Further, Foucault criticises ideology, but Ingram states that he must "*ground the act of critical de-legitimation in something (some reason) that he takes to be legitimate*" (2003; 270). Therefore, Foucault *must* believe in something; he must have some ideological base. Arguably, Foucault's ideological base is that there are more than one legitimate ideological base and that dominant ideologies should be challenged. That means though, that all truth and knowledge is illegitimate and unjust; if this is so, it is difficult for Foucault to claim truth in his descriptions and interpretations (Ingram, 2003). Foucault does not claim to tell 'the truth'; his interpretations and methods advocate for multiple truths to exist simultaneously, his discord was with certain truths being peddled as 'the only truth' by the powerful in society.

¹³ Foucault suggests that discursive practice is based upon the science or institution that created it. Truth is demanded as much as power; it moves through many layers of education and information gathering; it is created and controlled by a few elite institutions (for example, education, media, the army) and is at the centre of ideological struggle (Danaher, *et al*, 2006; 24-29).

Essentially, Foucault views discourse as disciplines (defined as bodies of knowledge) and disciplinary practices (forms of social control and social possibility) ((McHoul and Grace, 1995; 26). Here discipline is used in two senses:

- As a scholarly discipline such as medicine or psychology.
- As a disciplinary institution of social control, such as prison or school.

Foucault views discourse as '*Well-bounded areas of social knowledge*' (McHoul and Grace, 1995; 31). Everything is written about, thought about and spoken about in specifically historical ways. These ways are constrained by the time and culture, which ensure that concepts are defined in certain ways and not others. "*A discourse*" would then be whatever constrains – but also enables – writing, speaking and thinking within such specific historical limits' (*ibid*). That means that discourses do not only represent the real world, but also form part of its production and what we can imagine, never mind put into practice, is permitted and constrained by the discourse available.

Foucault did not view discourse as the techniques, structures and the forms of 'know-how', which allow people to produce and recognise utterances. Instead he wanted to look at discourse at the level of the statement¹⁴ (McHoul and Grace, 1995; 36-39). A statement must be part of techniques which produce human subjects and institutions. It is not a unit of anything, but more of a function, not described in terms of its size, etc. but in the units function that expresses and reveals the structures in discourses (McHoul and Grace, 1995; 36-39). In this thesis such statements are referred to as repertoires (Marshall and Raabe, 1993). Repertoires are statements which serve functions, for example; "everyone has a learning disability of some kind" – this repertoire serves the function of lessening the differences between people with a learning disability and people without.

Repertoires set up relationships with other such repertoires and are referred to time and again in the discourse (Marshall and Raabe, 1993; Danaher, *et al*, 2006; 30-45). They allow for actions to take place, by either being absent or being said. For example, before the Mental Health Acts (MHA), forensics did not exist as a nursing specialty. It was not until learning disability was seen as a sub-set

¹⁴ Statements should be parts of knowledge. It is not the same as a speech act, as 'I love her' in marriage and 'I love her' in friendship are the same speech acts, but each is a different statement; and occurs in different historically formed discursive practices or 'technologies' and produces different human subjects – lovers or friends.

of the group termed 'mental' (which appeared in the MHA), that people with a learning disability could be detained - before then, forensic patients and the discourses surrounding them, did not exist.

Discourses always function in relation to power relations. Here, power is different; it isn't an effect or end product of existing power, and not merely domination of the powerful. Discursive power is everywhere and comes from the bottom up, not just from the top down. It exists in politics, families, institutions – everywhere. The macro and micro discourses we use every day carry discursive power.

The concepts of knowledge, power and discourse are intricately linked¹⁵. The next section of this chapter will examine the concept of power, leading to a discussion of relevant parts of Foucauldian analysis related to learning disability and forensic practice to illustrate the methodology and the discourses he exposed.

Power

Power cannot exist without the construction of knowledge which creates it; nor can knowledge exist without power relations, since power produces knowledge (Foucault, 1975; 181-194). Similarly in any society the relations of power which characterise the society cannot be recognised without the construction and distribution of discourse; power requires the truths which discourse produces in order to refer to them for authority:

'We are subjected to the production of truth through power and we cannot exercise power except through the production of truth'. (Foucault, 1980; 93.)

There are many forms of power in our society; legal, economic, education and the military for example, but they all depend upon techniques to exercise this power and refer to some scientific 'truths' to achieve authority. These techniques and truths differ historically, and are not necessarily universal¹⁶.

¹⁵ Foucault illustrates this through key texts such as *Discipline & Punish* (1975) and *The History of Sexuality* (1979).

¹⁶ Power is not restricted to a sovereign conception of power, meaning we are the subjects of power; indeed, despite his critics (Mills, 2003), Foucault describes power as 'polymorphous' (McHoul & Grace, 1993; 64), emphasising the productive character of power; producing ideas, concepts and institutions. Powerful discourses can be overcome; for example by the work of the disability movement, who used new and powerful discourses to unearth repressive practices, challenging power through criticisms of the *status quo*.

Challenging Power

Foucault did not ask who is in power, but how power installs itself and how subjects act as channels and vehicles for that power, how power produces subjects and how subjects produce it – to examine the processes of subjection. Power is not merely ideological according to Foucault, but takes place through instruments for recording knowledge – through observation, investigations and apparatus for control such as hospital records and scientific theory (McHoul and Grace, 1995; 1-25). Foucault did not wish to analyse power itself, but the “*modes of objectification that transform human beings into subjects*” (Faubion, 2002; 326). These modes included science and dividing practices. In science people are categorized by collecting information about them and then using that information against them; showing normal distributions and, more importantly, who lies outside of the norm. Dividing practices divide individuals from others, and within themselves, through self belief and self regulation. Some of the most common of his examples include: the rich from the poor; the sick from the healthy; criminals from the law abiding; and the sane from the insane.

To study power Foucault examined resistance to it by movements which have several things in common:

- they are transversal
- they have immediate goals
- they target the effects of power

Movements such as the Self Advocacy Movement share these characteristics, and are a good example of groups of people challenging power structures and the *status quo*¹⁷ and demonstrate Foucault's resistance to power. Importantly, Foucault showed that in resisting power these movements claim that they have the right to be different and that difference is good. This directly challenges the 'truths' of the state and is crucial here – the idea that difference is good is central to this thesis.

¹⁷ Goodley (2001), presents characteristics of the Self Advocacy Movement as: members who are people with a learning disability who move outside of their traditional roles to advocate for themselves and others with a learning disability. They represent an ideological change via changing terms used and demanding rights for people with a learning disability. They also create a new identity from characteristics traditionally viewed as weakness, using slogans such as 'rights not charity' (Goodley, 2001;14).

Such liberation movements are not set against the individual, but the government of individualization. This is the way that the state imposes who we should be as individuals, where power categorises individuals to feel like and be viewed as having certain identities; where individuals become subjects. One can be a subject of others and be under their control, and be a subject of one's own identity; both suggest subjugation to power and are related to disciplinary power :

'...they [the state] attack everything that separates the individual, breaks his links with others, splits up community life, forces the individual back on himself, and ties him down to his own identity in a constraining way.' (Faubion, 2002; 330)

Identities can be restricting, even when imposed from within.

Disciplinary Power

Disciplinary power takes many forms and historically 'defaulters' were punished by bodily violence in a show of absolute and sovereign power. In contrast, our society uses the technique of surveillance, by which the individual disciplines himself. The movement towards apparently more humane sorts of punishment was thought to be due to the general humanisation which accompanied modernity. Foucault, instead, suggests that it is a sign of the government of life processes – where those in power examine individuals and collect information, characterising them through normal and abnormal categorisation (Foucault, 1975; 107-127 and 184-194). Through his observations Foucault showed how institutions have long controlled how people think and act, even down to the *minutiae* of how we position our bodies¹⁸.

Individuals falling outside of these norms were shown to be given reduced privileges, lower status and even punishments, the purpose of which was to encourage them to shrink the gap between them and those who fell within the norms; and was deemed '*essentially corrective*' (Foucault, 1975; 179). This form of power develops docility and trains the individual to behave in ways which the society deems acceptable. Physical punishment or direct force is only necessary when this form of discipline fails (Foucault, 1975). Forensic settings are a recent example of such corrective practices.

¹⁸ Recent examples of this may be found in health promotion initiatives regarding smoking, diet and breastfeeding, to name but a few.

The Subject

'The distribution according to ranks or trade has a double role: it marks the gaps, hierarchizes qualities, skills and aptitudes; but it also punishes and rewards.' (Foucault, Discipline and Punish, 1975; 181)

Singling out those outside the norms of the institution served a twofold purpose; it encouraged those being punished to try harder to reach normative behaviours and discouraged those deemed to be within the norms from falling outside of them. Individuals are watched, examined, categorised and their movements recorded and through this the institution '*...compares, differentiates, hierarchizes, homogenizes, excludes. In short, it normalizes*' (Foucault, Discipline and Punish, 1975; 183).

Foucault believes that normalisation became an apparatus of power as it enabled differentiation.

Similarly, within the normalisation model of Wolfensberger described in Chapter 3, people with a learning disability are expected to change to be accepted by society and to fit in with society. Only then may they have access to '*the good things in life*' (Wolfensberger, 1998; 58). One such way in which the state regulates our activity is termed governmentality and is carried out in two ways;

- a. firstly we are regulated by the state, institutions and discourse
- b. secondly we are educated by the state so that we manage ourselves - we begin to self govern (because we see ourselves as citizens, we start to self-regulate) (Danaher *et al*, 2006; 46-62 and 82-96).

Those falling outside of the norms are viewed as deviants where vast assumptions are made about people because of one part of their lives i.e. their difference or, in this case, their disability. This categorization shows us who to study (the abnormal) and how to separate them from us. The ways that we are divided are termed 'modes of objectification' by Foucault.

Foucault has been criticised for giving a view of a completely normalised society, it is believed that this may be more about criticising society and to gain a large reaction to his work, rather than actually believing it (Ingram, 2003). Foucault did offer normalised views, but he acknowledged the importance of individuals and groups speaking out against these disciplinary practices and challenging normality as the only view. Foucault unearthed many practices of normalisation that are useful in this study. He pointed to problems with particular social practices such as, treatments, perceptions and histories of madness, and was of great conceptual help to the anti-psychiatry movement (Mills, 2003; 97-108).

However, how helpful his work is to people who are diagnosed with mental health issues, is debatable

(*ibid*) except for those who wish to break out of the medicalised view of different behaviour and seek alternative ways of dealing with different-ness, as in this study.

Modes of Objectification

Foucault described three modes of objectification of the subject which categorise and separate people. They are demonstrated through examining the relationship between science, knowledge, social practices and power relations (Rabinow, 1991; 3 -29). His historical searches of madness, criminality, and sexuality and how their concepts and classifications have been constructed at particular times, show the ways in which human identity is formed and codified (Foucault, 1961; 1975; 1998). The three modes are termed dividing practices, scientific classification and subjectification.

The first and most pertinent way in which subjects are objectified is through 'dividing practices' which explain how, for example, psychiatry separates the sane from the mad (Rabinow, 1991; 8). Here, people are divided from others or themselves through practices of categorisation through science or pseudoscience. This includes exclusion, where people are usually spatially isolated (but always socially isolated), because of abnormality - for example criminals are sometimes placed in gaol but also shunned by non-criminals. This categorisation leads to medicalisation, stigmatisation and normalisation (Rabinow, 1991;3 -29). Historical examples of such dividing practices are the ways in which lepers were confined during the Middle Ages, then the poor, the mad and people with a learning disability took their place in later times. It is used by a powerful group to divide, and also they use their own knowledge of rhetoric about reform and progressivity, whilst continuing to categorise people and create identity through dividing practices.

The next is related to, but not the same as, the first and is 'scientific classification' (Rabinow, 1991; 3-29). Foucault sees discourse as language working through institutions to show people how to make sense of the world. Here, science separates us through classification, for example biologically, through species, sex, disease and, most importantly for this study, people categorised as learning disabled.

The third of the dividing practices is subjectification, where we turn ourselves into subjects of, for example health, illness or sexuality. These are intricate processes which can include behavioural patterns, the language we use and may even include body transformations. Key to this subjectification is the understanding of ourselves and others who influence us, such as priests, counsellors and clinicians. These are the people to whom we relinquish control over our spirits, consciences, emotions, minds and bodies. One of the main ways that these dividing practices work is through the use of examinations or assessments. For the men in this study this occurs in many ways: they are judged by the state and by the medical and nursing professions, who exclude them and attempt to normalise them to some extent. Importantly, the men's surrender to these judgements is often seen as positive and their resistance to it as further evidence of their deviance.

In this thesis, such practices are described as practical ideologies. These are repertoires used by the participants and policies studied which exclude certain people and justify particular practices – they are usually prejudiced and described in non-prejudicial terms. Practical ideologies use values such as justice and care to justify the unfair treatment of others. For example in the Sexual Relationships Policy: (page 10) the following is stated:

'In the interests of maintaining necessary security, whilst providing for a therapeutic environment... to enable care... particularly where the issue of consent and safety is concerned, physical contact is not permitted between detained patients.'

The example above shows how language of care and concern are used to justify the withdrawal of a human right from detained patients.

Foucault's views were of dividing normalising practices were not the only views accepted - they were also shared by Habermas and Marx, even though the latter two would place these practices in the division of labour and intellect in a top down manner (Sawicki, 2003).

Foucault claims the resistance to power as being within power itself and his ideas rely on the subjugation of people; denying their own agency, ignoring the revolutionaries and resisters and 'vitality of humanism' (Habermas cited in Ingram, 2003) - but people do, in fact, speak out, as did Foucault himself (Mills, 2003; 97-108; Ingram, 2003). He later conceded that the self was a mixture of

coercion and the self – as he accepts that subjects can also use the relations of subjugations which constrain them (Sawicki, 2003).

Importantly, Foucault emphasised the fact that the professional and 'expert' view of people was not the only legitimate view. Foucault offers unconventional ways of viewing learning disability, mental health issues and offending behaviour. Foucault's view of the power and knowledge of experts as all bad and something to be resisted is questioned, as not all expert knowledge is bad and may, in fact, be used for the benefit of others. Examples of this include the pain and discomfort associated with some physical impairments or symptoms of syndromes associated with learning disability, where medical intervention may alleviate this, or where people have epilepsy and require medication to stabilise the seizures and increase their life chances and reduce their mortality rate. More pertinent to this thesis is the example of offending behaviour, where specialist treatments may help people to alter their poorly controlled or harmful behaviour and enable the men to live more enjoyable lives without harming others or themselves.

The chapter now moves into illustrations of Foucault's work which relates to learning disability and forensic practice¹⁹.

Foucauldian Discourses Related to Learning Disability

Foucault challenged the current view of mental illness as he viewed madness as not occurring within the individual as previously thought, but as being constructed by society, particularly through its institutions.

This was not an altogether fresh idea as the anti-psychiatry movement and its thinkers such as Laing (for example in 1961) and Bateson *et al* (1956), had long argued that madness was a concept which was derived, not from within individuals (as particularly written about using schizophrenia as an example), but as an individuals normal reaction to abnormal or faulty social situations. For example, the family and particularly mothers (schizophrenogenic mothers) may cause their family members to

¹⁹ Whilst *Madness and Civilisation* (1961) and *Discipline and Punish* (1975) are the most pertinent of his works for this thesis, other examples are included.

behave in seemingly bizarre ways because of the strange ways in which they have been treated themselves; in other words they did not have schizophrenia, they were merely reacting to abnormal family or social circumstances.

Because of his particular style of research he concentrated on power relations and discourse as the subject of his investigations rather than the individual, whom he saw as being the product of the two concepts. He traced madness throughout history and demonstrated how it was not a single concept, but one which changed culturally and historically through its construction. For example, madness was viewed as being animalistic in the classical period, and not as a medical issue as it has been viewed more recently. Also, currently a new view of mental illness is beginning to emerge where it is perceived not as a medical disease, but as an emotional disability (NIMHE. 2003).

The concept of 'madness' is used to define the sane and the mad, and separate the mad from the sane. Foucault's great interest is in what tools are used to develop the idea of madness and maintain it in society (Mills, 2003; 97-108). Foucault showed that the way in which institutions change affects the current view of madness, for example whether there are colonies or hospitals to house those considered insane. The mere existence of such facilities means that someone will be housed there and that who this is will be at the convenience of the era. Foucault demonstrated how the hospitals previously developed for people with leprosy, were later filled with the 'socially useless' when they were no longer required for their original purpose. Similarly, in our recent history, huge institutions built for people with a learning disability were filled during the 1950s and 60s, and then emptied during the 1990s at the beginning of the era of community care. More recently, those same institutions have been developed into specialist services for people requiring specialist treatment, such as people with a dual diagnosis, or offenders with a learning disability.

In *Madness and Civilization* (1961), Foucault traced the way in which the insane are perceived by society. Earlier in European history the insane were seen as a normal part of society. However, at the time of the great confinement²⁰, the insane were thought of as animalistic which gave grace to all

²⁰ As it became known because of the volume of people who were institutionalised at this time.

manner of fascination, myth and treatments. The practice of exhibiting those institutionalised has historically been common²¹, and Foucault comments:

'As late as 1815, if a report presented in the House of Commons is to be believed, the Hospital of Bethlehem exhibited Lunatics for a penny, every Sunday.' (Foucault, 1961; 64)

All forms of "unreason" were seen as being mad. However, madness was not yet seen as sickness but as something fascinating and dark or as a '*glorified scandal*' (Foucault, 1961; 66). The perception of the insane was changing from something that a man could be to something outside of man – something that made the mad different to the rest of society:

'Madness had become a thing to look at: no longer a monster inside oneself, but an animal with strange mechanisms, a bestiality from which man had long since been suppressed.' (Foucault, 1961; 66)

This change in perception of the insane, from men to animals - different from the rest of us and not human - could justify some terrible practices concerning those institutionalised. We can still see this today in the accepted practice of termination of babies prenatally diagnosed with disabilities. In fact, 10 -15 percent of children born with Down's syndrome are still put up for adoption by their parents (BBC, 2003). This is also often evident in writing on people with a learning disability as, most controversially, philosopher Peter Singer and others equate people with learning disabilities with animals, and go so far as to propose infanticide and replacement of disabled children:

'The conditions he has explicitly named as sufficient justification for active infanticide include Down's syndrome, spina bifida, and haemophilia.' (As discussed by Singer and reported by the Institute for Social Ecology, 2003; 1)

This animal-likeness was also believed to protect the mad from what we mere humans feel. For example, the insane were thought to possess superior powers to enable them to be protected from cold and heat, pain and suffering. In being animal-like they did not feel as humans do:

'Animality, in fact, protected the lunatic from whatever might be fragile, precarious, or sickly in a man. The animal solidity of madness... inured the madman to hunger, heat, cold, pain.' (Foucault, 1961; 69)

²¹ Indeed, when I trained in a long stay hospital in the 1980s there were disturbing reports by people living there that they had been exhibited in front of medical audiences to illustrate genetic syndromes.

Similarly, people with a learning disability are still thought of as having such powers. It is common for me to be asked by students whether people with a learning disability “feel pain...” or stating that people with Down’s syndrome have great strength. More recently there have been two disturbing reports from MENCAP - *Treat me Right* (2004) regarding the poor treatment of people with a learning disability in the NHS: and a follow-up report, *Death by Indifference* (MENCAP, 2007), tells the stories of people with a learning disability who have been neglected by the NHS in recent years and died as a result, not because of their learning impairment but through misunderstandings and lack of knowledge in NHS staff. This sparked a national Inquiry in which recommendations were made regarding their treatment, access to information and the education and training of all NHS staff (Michael, 2008).

The way in which madness is defined at any one time affects how people considered to be mad are treated - when thought of as animalistic they were treated with harsh physical treatment and when thought of as having an illness, they are treated with drugs and incarcerated in hospitals. The way that madness has been medicalised has stigmatised and detained some individuals and given status to professionals who are seen as specialists and able to handle and cure them (Goodley, 1998; Mills, 2003; 97-108). Similarly, when viewed with pride or pity the treatment is different. The Catholic Church appeared to have a different view of the insane; and Foucault refers us to St Vincent de Paul who stated ‘*Throughout his human life Christ honoured madness*’ (Foucault, 1961; 75. St Vincent de Paul here referring to text of St Paul; 1 cor., 1; 23). St Vincent de Paul is famous for reminding those who cared for the insane of this, as he suggested that Christ passed as a madman whilst on earth - implying that treatment would be different again, with people considered as mad treated as special, or with charity and to be pitied:

‘O my saviour, you were pleased to be a scandal to the Jews, and a madness to the Gentiles; you were pleased to seem out of your senses, as it is reported in the Holy Gospel that it was thought of Our Lord that he had gone mad.’ (Madness and Civilisation, 1961; 59)

However, this quotation suggests more than pity, as it includes pride in the thoughts of being viewed as mad as Christ made himself out to be. Indeed many discourses today pronounce disability as having positive elements to it and function to re-evaluate the view of disability in the eyes of society.

Examples of this include the writings of disabled people, the social and affirmative models and the Self Advocacy Movement, as stated aptly by Anya Souza, (cited Goodley, 2001; 217):

*'Who has 47 cells? I have. They haven't they've only got 46.....
My Dad says I'm 'Up Syndrome' not 'Down Syndrome'.*

Foucault demonstrated how concepts like madness or learning disability change historically and culturally, and along with those changes appear modifications in beliefs, knowledge, science and treatment. Discourse, knowledge and power collude to produce truths about the world we live in. Foucault observes individuals, not of themselves; their identity is viewed as the product of discourse, ideology and social practices (Danaher, *et al*, 2006; 30-45). Similarly people with a learning disability are viewed with suspicion because of their learning impairment and they are treated differently because of this. From a Foucauldian position, I argue that learning disability has become a discipline (a body of knowledge) and a disciplinary practice (where people are treated differently because they do not, or cannot, conform).

Summary

This chapter has explored how truths are constructed, communicated, used to police our behaviour and, more importantly, how these truths may be challenged. This thesis will use Foucault's methodological stance as a base to explore and challenge how people with a learning disability are classified as different and are identified as other (by themselves and others) and become subjects of illness, law and expert care. The discourse surrounding learning disabilities and their effects on how people with a learning disability are treated will now be explored in Chapter 3.

Chapter 3 - Dominant Discourses of Learning Disability

The last chapter broadly discussed Foucauldian analysis and views of discourse, knowledge and power and how people with a learning disability may be classified through, and become subjects of, discourse. This chapter develops the discourse theme and focuses on the dominant discourses that exist in learning disability and nursing: tragedy and medical discourses; social role valorisation (SRV); and the social and affirmation models of disability and shows how the treatment of people changes depending upon the discourse available. Issues of the disabled identity are discussed in relation to learning disabilities and, in particular, the chapter ends with an exploration of positive aspects of having a learning disability to enable the development of positive discourses for people with a learning disability in forensic settings. The discourses used by people with a learning disability are rarely heard and are accorded importance at the end of this chapter.

Following Foucauldian observations on madness addressed in Chapter Two, historical discourses and how they have impacted upon the lives of disabled people will now be explored.

Historical Perspectives of the Treatment of People with learning disabilities

Historically, people with a learning disability have been labelled as many things, including for example 'idiot', from the Greek meaning private person; 'cretin', which is a corruption of the French for Christian²² and referring to their status of being cared for by the church; 'lunatic' which is a Latin derivative for the strange behaviour associated with the waxing and waning of the moon. They have also been labelled with more positive markers such as the Irish '*Duine Le Dia*', literally meaning 'someone with God', a special person, set apart from the ordinary. Whether labelled positively or negatively, people with a learning disability have been literally set apart from the rest of society because they were viewed as different.

²² Also used as a term for congenital hypothyroidism

Personal Tragedy Model

Personal Tragedy is a discourse which views disability as an individual tragedy, not a social or political issue (Shakespeare, 1999; French and Swain, 2008), and it is an opportune paradigm for pity and control, according to Oliver (1990; 1-11). It relates to what society sees as the difference, or in this case the disability, and separates those who are different because of this; as a result discourses and practices relating to pathology, dependence and difficulties materialise (Goodley, 1998). The locus of this difference/difficulty is seen as being within the individual - in the treatment of people with a learning disability this has historically meant differentiation between people on the basis of different types of impairment. Such oppressive models encourages paternalistic and charitable interventions in people's lives by virtue of the fact of their impairment and have overtones of deficit which increase professional feelings of competence, caring and control (Goodley, 1998).

Normality is defined by the non-disabled – and, fundamentally, impairment is judged as a personal loss and a tragedy (Shakespeare, 1999). This means that people who are judged as not being normal can be pitied and treated differently to others. Just as Foucault suggested, the discourses surrounding groups of individuals determine how they are categorised and treated.

Educational Models

One of the first modern references to disability is from a physician called Itard²³ who made one of the first attempts to educate disabled people. At the end of the nineteenth century the psychologist Alfred Binet devised the first intelligence tests through testing his own children. In 1911 Stanford University used Binet's work to develop the Stanford Binet IQ test (Terman, 1916). As IQ was now considered a measurable concept, populations could be measured and could be 'normalised'. This marked the era of educational care, and because of the discourses available, there was some attempt to improve the lives of people with a learning disability through education. Around the same time Darwin's ideas

²³ In Aveyron local people found a boy in the woods acting wild like an animal - they suspected that he had been raised by wolves. They took him to the physician Itard who named him Victor and tried to 'humanise' him through education (Jean-Marc-Gaspard Itard, 1932).

were having a major influence on the thinking of the era. Francis Galton is considered to be the founder of the eugenics movement, and was a cousin of Darwin (Shakespeare, 2008). This movement postulated that the poor, the criminal, the disabled and the sick were a drain on society, and if allowed to breed would reduce the health and intelligence of society.

People with a learning disability were now viewed as a burden and a threat to society and attempts to segregate them to protect society and the next generations began (Shakespeare, 2008). The 1913 Mental Deficiency Act went some way to enable the segregation of people with a learning disability from society, but it did not go so far as others wished. Supporters of eugenics called for mass sterilisation²⁴. Feeble-mindedness²⁵ was blamed for promiscuity, criminality, alcoholism and other social ills. The eugenic discourses enabled a pseudo-scientific justification for prejudice against and the control of people with a learning disability (Shakespeare, 2008) and had a massive impact upon their lives. There followed mass institutionalisation of people with a learning disability into colonies over the next few years, which then turned into hospitals with the birth of the NHS. The eugenics and medical discourses enabled justification for the segregation of people with a learning disability from the rest of society.

The Medical Model

The medical model is a dominant discourse which classifies individuals on the type and severity of their impairment; they don't have epilepsy, but become epileptic; have not impaired leg movement but become cripples. One characteristic that they have, their impairment, becomes the whole definition of persons. As with personal tragedy, the medical model threatens to individualise and pathologise difference. Because of the dominance of this discourse it may be difficult for people to accept the social construction of learning disabilities (Goodley, 1998).

Nursing practice has historically been heavily influenced by this view of disability, where people with a learning disability lived according to their primary diagnosis; in houses with other "epileptics" or other people with profound impairments.

²⁴ Mass sterilisation of women with learning disabilities occurred in other European countries and was prevalent in North America (see <http://www.eugenicsarchive.org/html/eugenics/index2.html?tag=1199>).

²⁵ As learning disability was referred to, along with three other categories of: idiocy; imbecility; and moral defectiveness in the Mental Deficiency Act (1913).

Erving Goffman (1968) studied the treatment of people in such long stay institutions and, like Foucault, equated discipline in the institutions not with medical therapy but with the exercising of power by the medical staff there. He described the insular world experienced by the patients²⁶ which meant that people living in long stay hospitals became a number, rather than the separate personality they once were. These conditions were created, not always because of nurses who were uncaring, but by overcrowding in under-stimulating environments, lack of privacy and individual care, lack of communication skills, segregation of the sexes, poor staff attitudes, labelling of people and a consistent denial of individual needs.

Things slowly began to change in the mid twentieth century when new ideas and disciplines were emerging, together with adverse reports from the long-stay hospitals and pluralist groups (Globe, 2008). In 1958, Jack Tizard, a psychologist, placed children previously living in institutions in Brooklands House. The results of the experiment showed improvements in the cognitive ability and behaviour of the children, demonstrating that children raised in a more ordinary environment with more staff and a stimulating lifestyle would learn and develop.²⁷ Evidence of the harm of living in institutions was beginning to emerge. Later the United Nations *Declaration of Rights for Disabled persons* (1975), and *Better Services for The Mentally Handicapped* (1971), stated automatic hospitalisation should cease.²⁸ The latter document set out the framework for the relocation of people back into their local communities through maintaining that their local authorities had the duty to provide them with suitable accommodation. Following this, The National Development Group (1978) - *Helping Mentally Handicapped People in Hospital* – commented that there were:

'50,000 people living in hospitals, 20,000 of them have been there for more than 20 years... Anyone who looks at mentally handicapped hospitals today, cannot help to be struck by the discrepancy between the quality of life of the general population and that of the mentally handicapped hospital residents... The physical conditions under which mentally handicapped people are expected to live and work for year after year, have long been regarded as unacceptable for the rest of society... This comment has been reinforced many times by the media.'

These were strong words and some believed that the hospitals would have to close immediately. However, thirty years later there were still people living in long-stay hospitals.

²⁶ He also listed the pitfalls in hospital care at that time; rigid routines, social distancing, block treatment and depersonalisation.

²⁷ This was confirmed eight years later by Kushlick (1967).

²⁸ The size of hospitals for people with a learning disability in England should be reduced by 50 percent by 1990, and children should not be admitted. Hospitals should only be used for people with severe challenging behaviour (Globe, 2008).

To an extent such medical practices still occur today within some treatment and residential services, where people with behavioural or mental health needs, or people who have an autistic spectrum disorder, live together because of this diagnosis, rather than because they choose to live together. Currently, only 6 percent of people with a learning disability have a choice in who they live with (DoH, 2001). Presently (2008), there is continued specialisation in health care for people with a learning disability, with growing interest in areas such as treatment and assessment, mental health and behaviour which challenges services and forensics. Again the focus is on the perceived medical impairment and its treatment²⁹.

Whether learning disability is an absolute at all has long been debated (Williams, 1989) and, in fact, in 1969 the American Association on Mental Deficiency (AAMD) placed the threshold for learning disability at an IQ of 85, one standard deviation (SD) below the mean (set at 100). This meant that 16 percent of the population was considered to have a learning disability (Smith, 1976). This was subsequently re-thought in 1973, moving the threshold to two SDs below the mean, and learning disability was then redefined as occurring at an IQ score of 70 or below, with 2.25 percent of the population now categorised as having a learning disability (Smith, 1976). Overnight, nearly 14 percent of Americans were restored to health. This constitutes an enticing argument for the social construction of learning disability.

During the 1970s Wolf Wolfensberger was developing and refining his ideas on normalisation. He, and others³⁰, proposed that services should change so that people living in the institutions would be enabled to live life as close to the 'normal' enjoyed by the rest of society as possible (Globe, 2008). These ideas were based upon human rights and role theory.

²⁹ This is similar to the ways that Foucault described the categorisation of the mad throughout history; a categorisation is developed through collecting information and developed into a specialism, with specific knowledge and practices, enabling people to be categorised and treated accordingly.

³⁰ For example: Bank-Mikkelsen, Nirje (see Emmerson, 1992).

Social Role Valorisation

Learning disability nursing practice (RNLD) is underpinned by the ideologies and discourses of social role valorisation (SRV) (Gates and Beacock, 1997; Wolfensberger, 1998). Historically, this impacted positively upon the lives of some people with a learning disability, who had previously lived in appalling conditions in institutions, but it has been criticised heavily almost since its conception (Atherton, 2003). SRV is an ideology which is based upon the premise that people are devalued because they have more negative social roles than positive (Wolfensberger, 1998. See section on 'wounds'; 12 - 24). SRV suggests that changes in the behaviour of disabled people will lead to more positive social acceptance. Importantly, this discourse is about changing the behaviour of people with a learning disability in order to be accepted by society, not about changing society. It proposes that certain groups of people in our society are devalued by the society because they do not fit in³¹. Central to this ideology is the proposal that these devalued groups can be elevated in the eyes of society, through increasing their valued roles and decreasing their devalued roles, by normalising themselves through skill acquisition and thus demonstrating to society that they are not that different from them.

However, this presumes that people with a learning disability understand that they are not accepted by society and that they wish to be accepted and, further, that society will indeed include people with a learning disability if they appear to have more positive roles. Importantly, this model did not emerge from disabled people, but from academics and professionals. This is apparent in the views expressed within SRV. For example, it is societies' values of independence, not disabled peoples' views that SRV promotes; disabled people may have a completely different view of independence. For example, many people rely on others to live day to day; celebrities have entourages of people who care for their nutrition, hair, dress, make their appointments, answer their mail, etc. - meaning they are not independent, but they are clearly still valued by society. As one self-advocate states:

'I may need help with some things but I'm not retarded. I can take care of myself... Everyone needs help. Some people need more. Even the ones on the outside – the normal people, have marriage counsellors and other people to help them.' (Martin Levine in Friedman-Lambert, 1987, Cited in Goodley, 2000; 124)

³¹ These groups are those which society sees as having devalued roles, such as older people, unborn children, the poor and people with a learning disability.

In fact, disabled people may believe other values to be more important than independence. For example, self-advocacy may be more important to people with a learning disability than independence.

Wolfensberger's work appears to be based heavily in theory and its claims to be scientific are questionable (Robinson, 1989). Despite this, it impacts greatly upon nursing practice, whereby nurses spend a great deal of their time helping people to acquire skills that they may, or may not wish to acquire. Registered nurses for people with a learning disability (RNLDs) strive not only for the good health for people with a learning disability, but also for the acceptance of people with learning disabilities into society. In doing so, the profession can impose immense pressures on people with a learning disability to achieve³².

Furthermore, the development of positive or valorised roles in a forensic setting may be very difficult and restricted by the need for security, legal status and the risks people pose to themselves or others (Williams and Dale, 2001). Current literature argues that using SRV as a model for all people with a learning disability may not be ideal, but is still imposed by carers, integrated into current nursing models, and its concepts and principles are still expressed in policies and legislation, including those affecting people living in secure settings (Gates and Beacock, 1997; Atherton, 2003). It is clear that in true Foucauldian terms the way in which devalued people are treated depends upon the models and discourses that are dominant at the time.

What is important is that throughout the literature on SRV it is apparent that people with a learning disability have little say over the discourses affecting them, as they emerge from and are developed by academics and professionals, which is clearly unacceptable:

³² Using SRV, nurses enhance the skills of people with a learning disability to achieve some sort of independence, and this makes some sense; skill acquisition helps with physical tasks and has psychological benefit, as in raising self esteem, and may be more important in forensic settings where patients maintain negative roles of patient, offender, ill, mad and dangerous (Williams and Dale, 2001). Often the teaching of the skill may take so long that it leaves little time for any other enjoyable activity, especially as learning such skills may take years, not just hours (Corbett, 1997).

'The problem with that lot was that they'd never had a Down's Syndrome baby. 'Normal people' were in the association, I was the only one with Down's Syndrome working in that office for ten years.' (Anya Sousa, cited Goodley, 2001; 129)

'This is my experience. Every experience is totally different and you need to go back and ask self-advocates.' (Jackie Downer, cited Goodley 2001; 132)

The Social Model

Challenges to academic discourses essentially began with The Union of the Physically Impaired Against Segregation (UPIAS, 1976) which was a group of disabled people in the 1970s who produced "fundamental principles" that showed the way for the emancipation of people with impairments. This document was very influential in defining the social model of disability and the social oppression discourse.

The social oppression discourse is an alternative to the presentation of disability as an individualised problem. It proposes the idea that disability itself has been constructed as a form of social problem; much as Foucault demonstrated how madness is a construct and how learning disability was re-constructed in America in 1973. Society, they argue, makes them disabled, not their impairment. It is through issues ranging from attitude to more practical things like access to public transport and segregated schooling that disables them, not the impairment. It is living in a society constructed by and for non-disabled people that disables people with impairments (Oliver, 1990; 60-77). The negative discourses surrounding people with disabilities are challenged by the social model. Theorists, like Oliver (1990; 43-59), draw our attention to the perceptions that society has about disabled people, commonly in terms of problems, and an inability to function normally. Disabled writers point out that even though they are classed as disabled they lead perfectly happy, useful and fulfilled lives (Swain and French, 2000). A disabled person may need twenty-four-hour help in his everyday tasks, but this doesn't mean that their lives are not fulfilled. This is a judgement put upon them by society; a value judgement based on someone else's experience. Their experiences may be different, yet can still be fulfilling and valuable. The social model enables recognition of the social, oppressive and discriminatory issues which may have contributed to the offending behaviour of forensic patients.

Throughout the eighties into the nineties changes occurring as a result of the Mental Health Act (1983) (MHA) developed new definitions and terminology and produced a code of conduct and guidelines for people using the MHA. But people with learning disabilities continue to be seen as a subset of those people termed 'mental' (Beacock, 2005)³³. The NHS and Community Care Act (1990) set out the ways in which people should be better cared for within the community, rather than within specialist institutions. In 2001 the Government released the first White paper for thirty years - *Valuing People: A New Strategy for Learning Disability for the 21st Century*. It was developed in consultation with some people with a learning disability and looks at the current problems and challenges; ageing, housing, employment services, quality, supporting carers and delivering change for the better. Implicit within *Valuing People* are principles of SRV and the social model of health and disability. It added some value to *Better Services* (1971), but unfortunately called for similar actions to those expressed thirty years earlier, suggesting a lack of progress in the care and treatment of people with a learning disability in our society. Pertinent passages from *Valuing People* are analysed throughout this thesis.

The Affirmation Model

The affirmation model (Swain and French, 2000) is a model which emerged from the disability literature and movement and has positive non-tragic view of disability and a proud group identity. Here, the different-ness of people with a learning disability is celebrated, and sameness is not necessary. Importantly, this discourse emerged from views of disabled people and here the discourses reflect the idea that people who are disabled do not have to change; and accordingly its implications for nursing practice differ from SRV³⁴. The affirmation model proposes that the solution for disabled people being devalued does not lie merely with a change of behaviour on the part of disabled people (as SRV suggests), but with the re-framing of their experience in a more positive light.

The affirmative model of disability directly opposes the personal tragedy view of disability, and argues that having impairments can have benefits. The literature discusses cases of disabled people who

³³ This is discussed in more detail in the next chapter.

³⁴ For example, independence in the affirmation model does not essentially include skill acquisition, or normalised behaviour. Instead, it includes independence of identity and of self; accepting the difference in behaviour and skills and challenging the simplified popular views of independence.

have received better education and escaped poor backgrounds because of their disability³⁵. These writers take a different view in many respects to Wolfensberger (1998) in that, instead of attempting to impose social values to make people fit in, Swain and French (2000) argue that disability should include positive social identities of different-ness. Disabled people do not need to change; but their experiences need to be re-evaluated by society in positive terms (Swain and French, 2000).

Writings from self-advocates show how people with a learning disability can build strong, positive identities. The standards of this group do not necessarily have to reflect those of society, which include valuing youth, intellect, beauty and wealth. Such a positive and proud group identity, which has helped the disabled to create positive images of and for themselves, enables them to be equal *and* different. However, how this may be interpreted in forensic settings is questionable as nurses detaining patients may be doing them no favours by not attempting to help them to change their offending behaviour – especially if that means that they will be detained for longer periods (Inglis *et al*, 2004). In line with affirmative models, nurses should not only acknowledge value in difference, but champion it; relinquishing their power and responsibility to the independent choices of people with a learning disability (Inglis *et al*, 2004).

The Disabled Identity

The disabled identity is a hotly contested issue in the literature and some would argue that disabled identity is constructed; its meaning is inscribed in relations of discourse and power, and enforced '*Identities will enslave us whether they are imposed from within or without*' (Phelan, 1989, cited Galvin, 2003; 675). There is an irony in this disabled identity which means that whilst trying to create an in-group, one automatically creates an out-group. One might wish to become part of a group, even one which is on the fringes of society, and as such disabled people's different-ness is used to fit into this group. If difference is used to exclude others from this group that means that the abnormal / normal binary opposition is used to exclude people from their group (the same one used to exclude disabled people from other groups in society) and this may only strengthen this binary opposition and

³⁵ This does not mean that people with a disability may not be more vulnerable to neglect and abuse because they are disabled or that aspects of disability are always seen as positive (Crow, 1996, cited in Shakespeare, 1999).

the polarisation of people's view of normality and of what is, and is not, acceptable (Watson, 2002). This is an ideally Foucauldian concept, where challenging the dominant ideologies by using similar arguments may be self-defeating. Whether this group is seen as positive or not, it is still a stereotypical categorization and can be offensive:

'This woman had put in the local paper, 'Mentally handicapped are simple and happy people'. I read it and thought the cheeky so and so.' (Joyce Kershaw, Cited in Goodley, 2001; 124)

This is not to say that the social model of disability and the disabled identity has not been crucial in the disabled movement and in the political successes that have occurred (Goodley, 2000; 26-45). Disabled writers present the disabled identity as one which is fixed and based upon shared experiences of oppression and physical restrictions (Watson, 2002):

'...many of us couldn't fit into the mainstream view of the world if we wanted to - and some of us wouldn't want to if we could!' (Younkin, 1989; 31, Cited Peters, 2000; 584)

There may be a plurality of identity and this should be explored, as many disabled people may see their impairment as a normal part of themselves. In fact, in Watson's study the paradox was that disabled people saw themselves as normal and as different *'...but importantly, this difference has little or no consequence'* (2002; 520). Watson (2002) describes how, out of the twenty eight disabled people he interviewed only three participants incorporated their impairment into how they described their identity.

Peters (2000) suggests that even though there may be a disabled culture, their own impairment is not always central to their own self-concept as for some, their disability is secondary to the poverty or pain they may be encountering. In fact, disabled people do not share religion, politics, social class, age, gender, ethnicity or sexuality, they merely share some of the experiences of disablement; they do not share impairment. Therefore, Watson (2002) argues that the idea of a common identity purely based on impairment is not sustainable.

Although Peters (2000) sees disabled culture as important, she also believes that the ideologies, discourses and models upon which it rests need to move on from critique to action. She sees disabled discourses as reactionary and oppositional, rather than attempting to provide a disabled world view. These, she hopes, will reclaim disabled identity from that of being the "other". It can be argued that this cannot be achieved successfully by re-using binary oppositional arguments.

However, a further paradox emerges when this identity attempts to include people with a learning disability.

Learning Disability, culture and theories of disability

It is often difficult to equate the writings of the disability movement with the lives of people with a learning disability (Simone Aspis (self-advocate), cited Chappell *et al*, 2001, Goodley and Armstrong, 2001). This problem is twofold. The first issue is that people with a learning disability are sometimes seen as being, and often wish to be, outside of the disability movement (Goodley, 2001; 209-216). A second related issue is that they are seen as people for whom the social model of disability cannot apply, as the problem is seen as one which occurs *within* people with a learning disability and not just within the way society is structured,, viewing learning disability as different from other forms of disability:

'Can I speak now? You should see what I've got - I've got two arms and two legs, I'm not physically handicapped actually.' (Anya Souza, cited Goodley, 2001; 216)

Docherty *et al* (2005) state clearly that people with a learning disability feel left out of the social model of disability. Yet they are disabled by society too; in the form of physical barriers, but also with inaccessible information, jargon and offensive terminology which compound negative attitudes and justify people not listening to them and being patronising.

In his article entitled 'Hierarchy of Impairments', Deal (2003) describes the differing likes and dislikes of certain impairment groups that are held by both the non-disabled and the disabled; unsurprisingly, learning disability is reported to be one of the least desired disabilities. In fact, he states:

'When asking a person who uses a wheelchair what they find annoying, it is not uncommon for the response to be related to being thought of as someone with a learning disability.' (Deal, 2003; 898)

This is also apparent in the current (2008) 'Creature Discomforts' adverts on television and radio which are designed to raise awareness of disability issues. Some of them merely restate that disabled people are not stupid. Whilst these adverts use the actual words and voices of disabled people, they do little but dispel the myth of all disabled people as having a learning disability; they

do less in the way of raising the value of people with a learning disability in the eyes of society:

"People have assumed that wheels [using a wheelchair] mean, nothing up here, in the brain you know," one creature states (<http://www.creaturediscomforts.org/watch> TV Ad 3).

Possibly because of this, some disabled people do not want to be associated with people with a learning disability, and some evidence suggests that people with a learning disability may have their own prejudice against physical impairment, as this quotation suggests:

'Learning disabilities - I don't like that, disability makes you believe that we are in wheelchairs and we can't do anything for ourselves, when we can. We've got jobs now, we've got paid jobs.' (Joyce Kershaw in Sutcliffe and Simmons, cited Goodley, 2001; 217)

This is an essentially Foucauldian idea; one in which identities are viewed as prescribed and which entrap ideas about the person, because of their supposed disabled identity. Yet whilst most people might accept the social construction of physical disability, it remains harder for them to accept the social construction of learning disability – it may be argued that society should cease analysing learning disability with biologically determined assumptions (Goodley, 2001; Simone Aspis, cited Chappell *et al.*, 2001). As the affirmative model suggests, the person with a learning disability does not have to change in order to be valued by society, rather, his/her experience should be re-evaluated in more positive terms. Although, such a notion appears noble, it is not always possible to create an identity that fairly represents all people with a learning disability – because it is viewed as the most tragic disability and may not be a homogeneous group after all.

The men in this study are susceptible to the negative discourses associated with learning disability and these issues are further complicated by the fact that they have complex learning disabilities, and are held in a secure environment. These issues affect their views on the world, the relationships they have with staff and researchers, and their ability to reject negative discourses and to create positive identities. The next section addresses the dominant discourses and what they could mean in the context of secure environments and forensic practice.

Ideology, Tensions and Nursing in Secure Environments

'We are who we are as people with impairments, and might actually feel comfortable with our lives if it wasn't for all those interfering busybodies who feel that it is their responsibility to feel sorry for us, or to find cures for us, or to manage our lives for us, or to harry us in order to make us something we are not, i.e. 'normal'. (Colin Cameron, Tyneside Disability Arts; 1999; 35. Cited Swain and French; 2000; 577)

The tensions that exist for forensic practitioners here are those concerning giving real choices to people with a learning disability whilst helping them to work towards reducing risks which would enable care to be delivered in conditions of lower security and, ultimately, release. As a part of the taught element of the Doctorate I carried out a discourse analysis related to the tensions which may exist for nurses using SRV or The affirmation model, and then collaborated with colleagues in high security settings to explore the uses of both models (Inglis *et al*, 2004). This work suggested that when using these discourses as a comparison, nursing practice incorporated tensions regarding independence and inclusion and how this is underpinned by the theme of difference.

The concept of difference is framed in a dissimilar way in both discourses; SRV striving to hide difference, affirmation venturing for pride in difference. The work with colleagues suggested that SRV might be a more useful model in current high security settings as it encouraged skill enhancement and a change in behaviour (Inglis *et al*, 2004). It is questionable, though, whether those who learn new skills automatically become more valued in society (Robinson, 1989). SRV means nurses are compelled to encourage people with a learning disability to toe the line and so nurses may end up policing the behaviour of those in their care to help them to enhance their social roles in accordance with Wolfensberger's, and ultimately policy makers' views. This is especially true in secure environments, as a priority of treatment is to encourage a change in behaviour and finally lower risk, so they may move into lower levels of security; nurses would not be doing patients any favours by failing to encourage a behavioural change as such failure may mean that patients may be incarcerated for longer.

Paradoxically, nurses may value the different-ness of the people they work with and may fear that it may be viewed as romantic, patronising, or as 'heresy' against the dominant ideology of normalisation (Robinson, 1989; Kemp-Harris, 1995) or as neglecting their duty if they fail to police and change behaviour which may be considered inappropriate or bizarre. Of course, the behavioural change that

is required by people in secure settings is often linked to dangerousness or risk, and may not be an intrinsic part of their personality. Therefore, risks can be lowered without losing the essential uniqueness of personalities. Using the affirmation model, nurses would be compelled to encourage self-expression to help people with a learning disability to be empowered. Nurses would have to take a back seat in decision making. This does not fit well with current forensic policy and may not be conducive to lowering risk. However, alternatively viewed, affirmation would enable nurses to encourage people to make their own decisions about how they wish to alter their risky or dangerous behaviour and give them the confidence to change. People with mild a learning disability may wish to fit in, to normalise, and it is the nurse's duty to help them to achieve that. Others may choose not to follow society's expectations, and may need support in dealing with the possible negative aspects of this choice; as with people in secure environments where sustaining dangerous or bizarre behaviours may mean a longer stay in security.

It perhaps should not be a debate surrounding which model or theory to choose, but which parts suit individuals, and which discourses shape practice best to suit individual needs. As Swain and French note:

'Perhaps the most intrusive, violating and invalidating experiences, for disabled people, emanate from the policies, practices and intervention, which are justified and rationalised by the personal tragedy view of disability and impairment. The tragedy is to be avoided, eradicated or non-disabled (normalised) by all possible means'. (Swain and French, 2000; 573)

This study will examine such discourses in the context of forensic practice. It is not only professional and academic debate, but includes and affects the men; their voices must be heard. This thesis studies the macro and micro discourses in such settings and addresses such paradoxes that exist for the men who reside in the MSU and the staff who work with them.

There are many negative discourses surrounding people with a learning disability. In fact Dune (2001)³⁶ found 99 percent of articles about people with a learning disability to be negative. Furthermore, there still exists lack of awareness of disabled issues. Many people who are disabled still suffer bullying and harassment and a poor attitude towards them (Poole Partnership,

³⁶ Reviewed all appropriate articles about learning disability from 1992-2000 (2,789 articles)

2006; MENCAP, 2007; Quarmby, 2008; 7-19). Reinders reminds us legislation, ideology and theory may have little impact on peoples' lived experience:

'My son has all the rights the ADA [Americans with Disabilities Act] can secure, but he still has no friends'. (Reinders, 2000 reported in Halstead, 2002, Page 36)

This study deliberately wishes to emphasise the positive aspects of learning disability to throw out the common negative assumptions. As Finkelstein (one of the founders of the London Disability Arts Forum, at the launch, in his presentation speech) comments:

'...through song lyrics, poetry, writing, drama and so on, disabled people have celebrated difference and rejected the ideology of normality in which disabled people are devalued as 'abnormal'. They are creating images of strength and pride, the antithesis of dependency and helplessness'. (Cited in Swain and French; 2000; 577)

Developing Positive Discourses of Learning Disability

As Foucault suggested, the discourses that are available have been shown to impact upon the treatment of disabled people. The following section of this chapter will examine the many positive discourses of people with a learning disability. Of course, the positive discourses are just that: they are discourses. It does not mean that they are particularly true, and they have no more claims to the truth than the negative discourses. The following paragraphs will explore these through commonly valued roles and characteristics such as employment, personal attributes and self-advocacy.

Employment

'In 1990 I heard about a job... I was desperate for the job. A teacher helped me fill in the application forms and I handed it in personally! I thought, 'I won't get the job'. The interview was two weeks later, I got there an hour early... I was scared, some of the questions they asked I didn't know, and I told them, 'I'm nervous'. They got back in touch with me two days later and told me I got the job. It brought tears to my eyes, it meant so much to get that job.' (Jackie Downer; 79-83. Cited Goodley, 2000; 80)

Many people with a learning disability wish to be employed and there is evidence that their employment may bring many benefits for the businesses and their non-disabled employees. This is evidenced by people with a learning disability and by non-disabled people.

Community Care magazine completed research in conjunction with *Personnel Today*³⁷ (Personnel Today, 2007) suggesting that organisations are beginning to understand the potential of employing people with a learning disability and reported that nearly 60 percent of the organisations employed people with a learning disability, 77 percent reporting this experience as positive. A separate poll of one thousand people with learning disabilities reported that employers needed to progress, as 81 percent of people with learning disabilities want to be employed but only 22 percent actually are (Personnel Today, 2007; Down's Syndrome Association, 2007).

Disability discrimination legislation obligates employers to accommodate disabled people in the workplace, through information and recruitment. A mere 12 percent of the organisations reported using specialised recruitment drives targeted at disabled people who may find non-specialist recruitment difficult. *Personnel Today* (2007) suggest that more people with a learning disability would be employed if these methods were more readily available. Reportedly 60 percent of Human Resources (HR) professionals stated people with a learning disability are employed because of their contribution to the workplace and are being employed in higher positions than people realise. This suggests that people with a learning disability want to work, make positive contributions to the workplace and that the impairment is irrelevant; what is more important is the understanding of employers and the adjustments to work-based practices - just what the social model of disability has been stating for over thirty years.

Personnel Today (2007) reported that the positives from employing people with a learning disability were not limited to their personal attributes, but that employers who developed specialist approaches to recruitment could be more successful in the future, as their creativity and robust recruitment approach may mean that they attract talent from their competitors and benefit from 'ability hidden behind disability' (Sherie Griffiths cited in *Personnel Today*, 2007; 3). A growing number of people with a learning disability are self employed and run their own businesses³⁸.

³⁷ 451 Human Resource (HR) professionals were surveyed

³⁸ The Lawnmowers, which is a theatrical group, is a particularly good example of this and Anya Souza discusses her work designing and developing painted glass ornaments and decorations: 'I mean, here I am living alone in my own flat and I do stained glass, which I sell' (In Goodley, 2000; 100, Chapter 5).

Self-Advocacy

'People with learning difficulties sometimes don't know what self-advocacy means. Broken down it means 'speaking up for yourself'... it means people must listen to me, I can take a risk... Some parents won't want their kids to do things and they need to have their own support group.' (Jackie Downer chapter 5 in Goodley, 2000; 80 and 81)

Self-advocacy is now considered to be a social movement (Goodley and Armstrong, 2001).

People with a learning disability argue that self-advocacy offers important collective opportunities for the development of confidence and challenging oppression. Not everyone has to be a member of a group, or be particularly supported to be a self-advocate³⁹; many people with learning disabilities may have advocated for themselves throughout their lives, with or without others' help (Goodley, 2000; 6-25). One of the main ways in which this is done is through challenging the negative and medicalistic discourses surrounding people with a learning disability through '**accentuation of the positive**' (Goodley and Armstrong, 2001; 12. my bold) by overturning notions of dependency and lack of ability, citing abilities and attributes.

Ensuring that positive aspects of people are exposed instead of discourses of deficit is important to self-advocates for their essential self-belief, interactions and risk-taking behaviour (Goodley, 1998). Foucault demonstrated that where there is power, there also lies resistance to it. In Foucauldian, terms the self-advocacy movement represents a challenge to powerful negative discourses. The importance of self-advocacy is further espoused in Goodley (1998), where its personal and collective actions were reported to enable the empowerment of people with a learning disability more effectively than other methods. Docherty *et al* (2005) are a group of self-advocates and researchers who quite strongly stated that people with a learning disability no longer wished for anyone else to speak on their behalf:

'Things have changed; the world has turned now. It's time to stop it always being professionals doing everything. We want people to listen to us and learn from us. We've seen tons of reports about learning disability... but most of the articles have been written by professionals who think they know about learning disability – people like Wolfensberger... but there's not a lot of writing from learning disabled people.' (page 31)

Self-advocates are now speaking out against discrimination against them and their peers, which includes other disabled people, presenting as barriers to good life chances, poor attitudes and

³⁹ In fact, labelling them as such, may indicate other-ness, as I am not called a self-advocate when I speak up for myself or others

inaccessible information (Docherty *et al*, 2005). They argue that it is not their impairment, but low expectations and assumptions about what they can achieve which disables them in society. Many people with a learning disability have jobs, relationships and children:

'I am able to do everything in my life like travelling on my own; helping in the community... helping older people... controlling my money... I am independent in many aspects of my life because my parents gave me the opportunity... they looked after me and gave me a lot of training and support in getting independent. My parents' attitude is positive to me and they don't believe that I am a disabled person.' (Paul Savage, 2005, self-advocate. Cited in Savage and Nourozi; 167-185)

Docherty *et al* (2005) envisioned a world without the disabling barriers for people with a learning disability - where information is accessible, there are no more negative ideologies; they are asked for their opinions, wants and needs; services are needs-led and not for financial purposes; and things are slowed down, so they did not have to rush; a world where people with a learning disability can complain and lose their temper without being labelled as displaying 'challenging behaviour'; and where they stand side by side with other disabled people to fight discrimination. Docherty *et al* (2005) work as self-advocates and researchers and are attempting to make their vision a reality through raising awareness, writing articles, speaking to politicians (including the Prime Minister), being members of prominent boards, running workshops and making sure that their information is accessible for others with disabilities and generally attempting to show people that people with a learning disability can do things and are not so different after all.

Goodley (2000; 199-220) describes the concept of resilience, which is closely linked to self-advocacy. He claims that it is contextualised in the time and the socialisation of the person (this is where self-advocacy groups may awaken a person to the potential of self-advocacy). It is a complex concept which is also optimistic as it challenges structuralist views of learning disability and questions the way that learning disability is viewed and how people's abilities are underrated. Paul Savage (2005) describes his life and his work as a self-advocate, and also helps other people with a learning disability in writing letters and training, raising awareness. However, he still does not get paid.

Attributes

'I'm quite lucky – I've got lovely neighbours, I feel that I've been more accepted into the community... That's not just because of the way I have got a place. My mum and I, we went for it, we said that people outside had to learn about people like me. That I wasn't daft, I wasn't a danger, I am a human being – I am just a normal person...' (Lloyd Page, chapter 5 in Goodley, 2000; 85)

One of the ways to challenge negative discourses is to promote positive attributes which people possess. People with a learning disability are said to have many personal attributes. For example, it is reported that they make loyal and enthusiastic employees and make valuable contributions to the workplace, often out-performing people without disabilities (*Personnel Today* 2007). People with Down's syndrome are reported to bring to the workplace higher staff morale, good business practice, reductions in staff turnover, increases in staff attendance and development of previously untapped talent. They are described as: *'Keen, reliable flexible workers who are ready to start at short notice'* (Down's Syndrome Association, 2007; 1).

'Would I say I have difficulties learning? No, I learnt well enough. I picked up things very quickly' (Anya Souza, Chapter 5 in Goodley, 2000; 101).

Employing people with Down's syndrome also gives a positive corporate image, as of a business which adheres to regulations, equal opportunities and diversity in the workplace. People with Down's syndrome are reported to be strong visual learners who learn through repetition, and their need for routine can benefit the organisation as they are often very meticulous in their work (Down's Syndrome Association, 2007). People with a learning disability have also been reported to be encouraging to each other, especially through effectively using humour, as Goodley reports (1998; 445), in his study with four groups of self-advocates:

'In all four groups, there were particular members who were able to make people laugh and put themselves and others at ease'.

'I've had an exciting life – I've enjoyed [working at] People First more than I did at the day centre because you do things all the time. I've done lots of things – I suppose there's not many self-advocates who could say they've been on the television twice!' (Lloyd Page; 83-88.. Cited Goodley, 2000; 87)

Confidence and opportunity appear to be good indicators of success in most people, and this is no different for disabled people. Raskind (2001)⁴⁰ found that self awareness, positive attitude and

⁴⁰ In his article entitled *Positive Attitude Trumps IQ, Good Grades as Success Predictor for Adults with LD*.

adapting to their learning disability was a better predictor of grade than IQ in 41 former students in California. He and his colleagues found that children with learning disabilities were more likely to succeed if they possessed certain attributes which they termed "success attributes", which included self-awareness, pro-activity, perseverance, goal setting, use of effective support networks and emotional coping strategies. As Lloyd Page states:

'At first it's difficult, it took me a long time but you need to gain confidence for yourself. You also need to believe in yourself, what you're saying and what you need to do.'
(Page, 2000; 83-88. Cited in Goodley, 2000; 85)

Similarly, Lemay (2005) suggests that people with a learning disability have great undiscovered potential through a story of neglected and abused twins, who each had an IQ of 40, but when given a stable, loving home their recovery was apparent and development returned to within normal limits. He believes that people's potential should be enabled as people are much more resilient than services believe:

'...resilience theory should inspire our positive expectancies for individuals and push us to create the opportunities required to maximize developmental potential. Resilience should be the expected outcome and all our interventions should be animated by hope'.
Lemay (2005; 6)

Lemay (2005) and others believe people with a learning disability have potentials which may become apparent when society ends their oppression and discovers how to unlock it. Interestingly, Raskind (2001) noted that successful people with a learning disability in his study compartmentalised their impairment, and saw this as only one part of themselves, not a defining feature. Self-advocacy is one such way that people with a learning disability can grow in confidence and realise opportunities to engage with positive support networks and gain employment in 'real' jobs.

This study will show how the participants recognise sometimes previously unknown abilities, confidence and attributes in the men who took part in this study. The results and discussions will enable the reader to discover the opportunities which the local study (LS) afforded the men to grow in confidence, self awareness, ability and skills. The men were always capable of this development, but reported lacking previous opportunities. The negative discourses which surround them affect the treatment and the expectations for them. The results of this study challenge such negative assumptions.

Summary

This chapter focused on the discourses common in nursing people with a learning disability and the effects that they have on nurses and the people they care for. These dominant discourses have been challenged successfully in recent years by using positive discourses of disability and the accounts of the narratives of those who are oppressed by them (Goodley, 2003). Similarly, this study will analyse the discourses which exist in theory, policy and nursing practice. However, the key to this study is that the authentic participation of people with a learning disability in research which concerns their lives, and the relationships experienced during collaboration in research, will be used as a tool to explore the ideologies, beliefs and the tensions that exist in nursing practice in secure environments and challenge them.

Chapter 4 – Forensic Learning Disability Nursing

This chapter builds upon the examination of discourses and how they affect people with a learning disability, to explore in more detail the impact of discourse on policy, culture and forensic practice.

'She was unhappy at the hospital and let everyone know it, with the result that she had the reputation of being a moaner. For a year she complained of stomach ache... There had to be an autopsy and it was discovered that she had in fact died of stomach cancer... I will never forget the funeral. There were two nurses representing the hospital, her mother, her aunt and me. The priest wore plimsolls under his cassock, and squirted holy water on to her coffin from a plastic squeegee thing. It was all over in minutes. Her mother kept asking the nurses whether she had left any money behind. Miriam was a victim of not being listened to...' (Louisa Reynolds, Brechin and Walmsley 1989; 32)

The above quotation describes the desolate funeral of a woman who had been institutionalised and ignored. Although nearly twenty years old, it is a powerful reminder of the effects of policy, culture and practice upon real people. Each of these influences will be addressed in turn with specific reference to forensic environments.

Policy

Policy in relation to people with a learning disability and their services *'reflects the beliefs, attitudes and values that an individual, group or a society holds towards people with a learning disability'* (Beacock, 2005; 2). Currently the purpose of detainment is treatment and not punishment - positive cultural values should be applied as this increases the success of such treatment (Williams and Dale, 2001)⁴¹. As societies' beliefs, assumptions and values are taken into account in the development of these policies, it also makes them susceptible to societies' myths, prejudice, stigma and discourse, particularly in relation to people with a learning disability who are involved with the Criminal Justice System (CJS). These prejudices may be reflected in the way the Mental Health Act (1983) (MHA) chooses to view people with a learning disability as a subset of those termed 'mental', and in the way that people with a learning disability are treated differently when they come into contact with the CJS.

⁴¹ Policy for people with a learning disability is predominantly influenced by the DOH. Although it is acknowledged that Home Office, education and Social Service policy has an impact, it is without the scope of the thesis to discuss policy other than Home Office and DOH, as they primarily affect this group of people and the nurses who care for them.

The ways in which people with a learning disability have been viewed are reflected in a number of historical policies in the UK and they have had little say in the development of such policies – negative discourse being reflected in practice has led to the sometimes inhumane treatment that they have received at the hands of societies who believed they were to be ignored, at best, or abused and eliminated at worst⁴²:

“...however uncomfortable the idea may be, it may be necessary to consider the impact that this logic has had on the development of forensic services in the UK since the 1920s.” (Beacock, 2005; 10)

There have been many changes in the way that the RNLD practices. Historically, his/her role began in the institutions which incarcerated many people who were considered different, and this included people with a learning disability. In the 1940s, nurses for people with a learning disability were entered onto the nursing register in England. The dominance of medical discourse meant that care was medicalised and disability seen as a disease to be treated. People within these hospitals did not receive their rights as adults. Eventually, there emerged new dominant discourses of normalisation and community care that meant massive changes for the RNLD; discourses effecting people with a learning disability were also affecting the RNLD⁴³. To those familiar with their medicalised training, they were frequently regarded as surplus to requirements and there were calls for a new profession to replace nurses and work with people in the community (Briggs Report, 1972; Jay Report 1979). Changes in public perception, the expert patient, the public's expectations in healthcare increasing and the growth of the social model of care means that the role of the learning disability nurse has changed, along with the philosophies, discourses and ideologies which inform its practice (NHS Plan , 1997; UKLDCNN, 2005).

Despite new discourses emerging, people with a learning disability are still excluded and segregated from general services (MENCAP, 2004; 11-22; 2007; 1-4; Michael, 2008; 13-22). Furthermore, there is growing evidence that people with a learning disability have a higher incidence of certain health needs that the rest of the population related to their continued segregation (disablement) from society and even health care, which impacts incredibly negatively upon their lives (MENCAP, 2004; 11-22;

⁴² For example the proposals of the eugenics movement (Shakespeare, 2008).

⁴³ In fact in Australia this idea was taken much further and they disbanded any specialist roles to care for people with a learning disability in the 1980s; this lasted 20 years and has now been reversed as it was thought to lead to increased vulnerability and insufficient service provision for people with a learning disability (Davis et al, 2001).

2007; 1-4; Michael, 2008; 13-22). People with a learning disability have the same rights to quality health care. However, this is not always evident in the care they receive as policy does not necessarily translate into fairer treatment and practice (Barr *et al*, 1999; MENCAP, 2004; 31-33 and 2007; 18-27; Michael, 2008; 13-22 and 23-32). An Independent Inquiry released in July 2008 described the importance of training and education for all NHS staff in the needs of people with a learning disability to ensure that they receive equitable services and are not discriminated against or neglected by the NHS (Michael, 2008; 53-56). As the only professional specifically trained to work in this field, the RNLD is best placed to enable them to remove barriers by involving people with a learning disability in mainstream developments, challenging discrimination within health services and through education and research – in fact, this is a key role (UKLDCNN, 2005; Michael, 2008; 53-56). However, in forensic environments, which are usually hospital-based and steeped in historical culture, the social model of health may not seem appropriate or be a priority in nursing people with complex mental and behavioural needs.

Valuing People (DoH, 2001) sets out key areas for concern, organised around four principles; rights, independence, choice and inclusion. The chapters are divided into themes ranging from problems and challenges to making change happen. Particularly pertinent to this thesis is the chapter on quality services which is concerned with services for people with specific and complex needs and mental health issues; people in secure environments and with behaviour that challenges services are represented in this chapter. *Valuing People* (2001) states that people with a learning disability should have access to generic services when at all possible, but this requires an increase in responsiveness for services to provide appropriate support. Furthermore, people with a learning disability and a dual diagnosis should have access to specialists in learning disabilities *and* mental health with specialist learning disability services available locally if required. It advocates for health promotion material to be provided in an accessible format and calls for strategies to improve housing, education and employment for people with a learning disability. Implicit within *Valuing People* are principles of SRV and the social model of health and disability. The same general policies and models serve the generic population of people with learning disabilities and forensic populations, although forensic services by their nature have additional policy and legislation to adhere to regarding security.

People with a learning disability have long been associated with the population of people with mental health issues. Historically this has been anchored in Legislation with the MHAs of 1959 and 1983. This continues today, where people with a learning disability and people with mental illness are viewed collectively under the term 'mental' and classed as 'one and the same' (Beacock, 2005;1). The use of the MHA for people with a learning disability has long been called into question and criticised, but it has been found to be being used appropriately (Kon and Bouras, 1996). Despite this, the Expert Committee (DoH, 1999a) to review the MHA suggested that people with a learning disability should not come under mental health legislation at all for the following reasons:

- The needs of people with a learning disability vary in range from those with mental health issues, and 'treatment' can be construed to involve a wide range of interventions.
- People with a learning disability can be dually stigmatised by being subject to mental health legislation.
- People with a learning disability rarely receive appropriate mental health services.
- Policy makers now recognise the difference between learning disabilities and mental health issues as one being a condition that fluctuates and the other being a lifelong condition.
- The structures of compulsory care and treatment are not appropriate for people with a severe learning disability.

For these reasons, current legislation is under review and viewed as outdated, as most of the patients are now treated in community settings, and the 1983 MHA allows compulsory detention only if the patient is in hospital. The Government believed that these powers had to change (DoH, 2000). The Draft Mental Health Bill, which was set to replace current legislation, was rejected by The Mental Health Alliance, because of its emphasis on compulsion rather than rights, and consequently withdrawn (DoH/Home Office, 2002; Beacock, 2005;). The MHA is being amended because of the demands exerted by pressure groups and this suggests that policy development is a complex process of many levels of consultation and amendment with many factors to influence it.

Despite current changes to the MHA it currently states that '*a learning disability is, in general, regarded as a mental disorder because it is a disability of the mind*' (DoH, 2008a. 1.13;19). Its appropriateness is still called into question for people with a learning disability because, unlike the rest of the population, they may still be detained without symptoms of mental illness if they are

considered to have “*abnormally aggressive or seriously irresponsible conduct*” on the part of the person concerned’ (DoH, 2008a; 1.14;19). A person with a learning disability cannot be detained ‘*solely on the basis of a learning disability*’ without such aggressive or irresponsible conduct – however, they remain the only group who can be detained under the Act without evidence of mental illness (*ibid*; 1.15; 20).

Whilst there are difficulties with some policy, there are also policies which overlap and send different and sometimes conflicting messages (Reed *et al*, 2007). It is clear that forensic services for people with a learning disability should be developed with this specific population in mind - the difficulty in following policy is highlighted when conflicts arise: for example, the compelling arguments against the subsumation of learning disability within mental health legislation (DoH, 1999a (Report of the Expert Committee)); whilst *Valuing people* (DoH, 2001) recommends the use of generic mental health services for people with a learning disability. Furthermore, the effects of policy upon practice are not clear-cut; some policies have more influence than others. The publication of the first white paper for people with a learning disability for thirty years (DoH, 2001) reflected the changing views of society, in that it emphasised rights, choice, inclusion and independence. However, the white paper has no status in law and is seen as mere guidance for the treatment of people with a learning disability in society. As such, the white paper has affected national and local policy and this can be seen in the language used and the aspirations which these policies express. Such policies are overlaid by other policies which affect the ways in which the policies are operationalised (Reed *et al*, 2007). For example, the NSF for Older People (DoH, 2001) states the need for specialised services for older people in England, while *Valuing People* (DoH, 2001) calls for the use of generic, and not specialist services. This leaves services for older people with a learning disability in a quandary as to which policy to serve - because of such policy overlap local specialist treatment services for older people with a learning disability, with the appropriate expertise and facilities, have closed when all over the country specialist older people’s services are being commissioned (Clarke *et al*, 2005).

Further, there is a need for the operationalisation of national policy into, sometimes, micro-policies, which are influenced by the organisational culture in which the policy is operationalised (Reed *et al*, 2005; Beacock, 2005).

Organisational Culture

The word “culture” means, simply, a way of life. EB Taylor (1958) described culture as

“that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society, later he added values, sanctions and goals” (Cited in Stanley and Swan, 2005;170).

Organisations are simply groups of people, so organisational culture includes a set of complex values and attitudes shared by the members of that group often called *“the way we do things around here”* (Stanley and Swan, 2005; 170). Service managers seek to *“inculcate a culture of shared meanings and assumptions that are directed towards achieving organisational goals”* (Riding et al, 2005; 170). In order to maintain control of the organisation and the needs of the people who work in that organisation, it is necessary to try to not only aid people to comply, but also try and get them to commit to that organisation. Not everybody sharing this culture experiences it, or behaves, in the same way.

Culture influences organisations and the beliefs that underpin them - the essence of the organisational culture is a set of beliefs, norms and values which have evolved and that organisational group members learn are essential to conform to, but of which only a few are expressed consistently and may be found in Appendix 2 ⁴⁴. These are expressed in cultural change which occurs, even in strong cultures, when new values are accepted at the macro level, enter policy and are imposed by the leaders of the organisation. However, the new values that are introduced must be proven to work, before they will be internalised by the members as assumptions and beliefs (Stanley and Swan, 2005; 169-190). The NHS is no exception.

At the macro-level cultural change is the key driver of the modernisation of the NHS which was steeped in mid-twentieth century thinking (Beacock, 2005). The primary drivers of quality improvement and patient-centred care come from the values of practitioners and an increasingly disgruntled public. As a result, there has been an increasing interest in evidence-based policy and

⁴⁴ According to Geert Hofstede in the 1970s people's approaches to their work are explained by four separate dimensions: power distance, uncertainty avoidance, individualism and masculinity (cited Stanley & Swan, 2005; 171). Please see Appendix 2.

practice in health to improve the quality of services. Central to this was an extension of the involvement of people who use the services in research, service and practice development. These changes have affected services in secure environments, but not always to acceptable levels (UKCC and University of Central Lancashire (UCLAN), 1999; 73-85). At the service delivery level the culture may be more difficult to change as members of the organisation have to learn new values. This appears to have been particularly true in the forensic services where several reports and papers continue to report security issues overriding therapy in these environments⁴⁵.

Due to variance between cultural values, nurses working in these environments can suffer severe role conflict, where their nursing culture tends towards care and the environmental culture leans toward security as the overriding concern. The UKCC and UCLAN (1999) found that routines and ritual regimes had not been replaced by evidence-based practice in these settings and that nurses sometimes found the physical security overwhelming. Whilst some services are uncertainty avoidant they also have to adapt to rapid changes in the NHS which are macro-organisational and value ridden. Managing these changes is to do with changing culture through altering the levels of culture, including the beliefs and assumptions of service staff. The government are clear - service managers are responsible for ensuring that practice is updated and, as the literature suggests, may be best placed to update the current culture in forensic settings.

Staff are the most important resource for the success of any forensic service, and therefore understanding their culture is essential to understanding their beliefs and assumptions which underpin their practice. Education and training is central to the development of forensic services and creating awareness that there will not be a return to the cultures and scandals of Ashworth and The Special Hospitals Authority Service Report (1993). Staff development in areas such as reflection, specialist knowledge, skills and attitude training are required to enable staff to negotiate the complex interpersonal relationships with abused and disturbed patients (Dale, 2001).

⁴⁵ As reported in: UKCC and UCLAN, 1999; An Organisation with a Memory, DoH, 2000; Dale and Gardner, 2001; 251-271

Forensic Practice

The forensic nurse role is one which is complex, has many influences⁴⁶, creates tensions within the role itself and entails the '*Protection of the public, risk management, community service development and human rights issues*' (Mason, 2002; 513). Forensic services are relatively new in the provision of nursing care for people with a learning disability and the services and roles are still developing. The issues in these services may be more complex than those in the general psychiatric services where nurses work with people who have a dual diagnosis of learning disability and mental illness. The RNLD has a role which includes facilitating and co-ordinating care and treatment and dealing with the day-to-day issues of the people in the service (Inglis *et al*, 2003). The staff should have specific expertise in learning disabilities, mental health issues and particular competencies (Watson, 1995 cited UKCC and UCLAN, 1999; 54-72) as they have unique responsibility for providing nursing interventions *and* for maintaining much of the security (Dale, 2001).

Each nurse must be deemed competent in specific knowledge and skills as well as judged as being of good character before they are entered onto the nurse register with the Nursing and Midwifery Council (NMC), and considered to be a 'good' and competent nurse (Smith and Godfrey, 2002; Bjorkstrom *et al*, 2006; Lofmark *et al*, 2006). Post-registration nurses are required to continue to develop professionally. Nurses are the only professionals who train specifically to work with people with a learning disability. Their training is diverse and holistic, meaning that they must have the ability to relate to many parts of the person's life including their hopes, dreams and health issues. These are, in turn, affected by life chances and behavioural and social issues. Thus nurses are ideally placed to work with such vulnerable people with diverse but complex needs.

Throughout the nurse education curriculum nurses learn that their work is underpinned by core values, knowledge and skills. They have values which include honesty, a respect for the inherent value and dignity of people and empathetic non-judgemental practice (Turnbull and Paterson, 1999; 99). They should develop a sound knowledge base including the biological and social sciences and psycho-social interventions, as well as political awareness and research. Their skills should incorporate critical thinking and communication skills, including how to co-operate and collaborate

⁴⁶ Please see figure 1 Influences on Forensic Nursing page 103

inter-professionally, and work in partnership with people with a learning disability and their significant others. Therefore, the focus of learning disability nursing interventions within the social model of health is upon building authentic partnerships with people with a learning disability to reduce or eliminate barriers to good health (Williams and Heslop, 2005; 243-243). This includes working with people who have offended, or have complex needs or behaviours, despite this approach seeming more difficult when working with people in a secure environment who are restricted by the MHA, the environment and their risk. This role additionally incorporates;

- Protecting individuals
- Enabling individuals to adjust to their losses (e.g. loss of freedom, family etc)
- Providing effective physical, social and emotional environments
- Intervening physically when necessary to limit risks
- Building and maintaining relationships with patients to reinforce their therapeutic goals, which is central to the role of the nurse and to effective therapeutic practice (UKCC and UCLAN, 1999; 54-72).

Mason (2002) examined the existing literature on forensic nursing and there was some debate as to whether forensic nursing is distinct from other types of nursing. Some of his findings are of interest to this chapter. Firstly, he found that positive aspects of forensic nursing in the literature were those relating to the nurses' attitudes; their commitment to patient-centred care; and to spending the greatest possible contact time with the users, thereby ensuring maximum time to engage in therapeutic activities. The literature highlights that nursing staff work under difficult and sometimes dangerous circumstances - yet strive to maintain a therapeutic setting (Burnard and Morrison, 1995). Forensic nurses also were reported to feel positively about the way in which they may control situations (Mason and Chandley, 1998), but this may also be viewed as a negative factor and one which complicates the role of forensic nurses in the therapy/security paradox.

Mason also describes negative views of forensic nurses from the literature as those relating to the nurses having pessimistic views of the offenders and poor perceptions of their own role. This is especially important as the patient may be exposed for a greater time to negative nursing views which may emanate from distaste for certain offences and beliefs that positive change is unlikely (Mason,

2002). Mason views security versus therapy as a key problem for forensic nurses as the security role within secure settings falls firmly on the shoulders of nurses. This is not true of other countries where security staff are employed for this purpose.

Closely associated to this issue is therapeutic efficacy which Mason (2002) describes as; *'the extent to which nurses feel that they are effective in their therapeutic endeavour'* (Page 516). Central to this theme is the therapeutic relationship, which he found to be reported as tense in the literature. This tension arose because of two main reasons; the first is the negative way in which the patient sees the nurse's warmth and sincerity to be a quality to be exploited in a system which s/he despises. The second is the way in which the nurse may be seen as friendly when the patient is getting what s/he wants and as a gaoler when s/he is not. This may leave the nurse feeling stressed or fearful and wishing to withdraw from patients. Indeed, Dale (2001; 127-138) warns that forensic nursing staff may be particularly vulnerable to being drawn into damaging relationships with patients, yet maintaining appropriate boundaries is key to their role. Related to the range of relationships encountered and efficacy of therapy is the culture which exists in these settings. The difficulty in getting the balance right between security and therapy has been discussed in terms of individual practitioners, but is also institutional, as the Ashworth Hospital Blom-Cooper Report highlighted in 1992, where the culture was seen as bullying and negative, yet a report seven years later showed Ashworth to be too liberal (Mason, 2002).

Mason's literature review also outlined several types of nurses identified in the literature and he describes positive and negative groups of staff and a middle "toggle" group of staff who would become positive or negative, depending upon who was in charge at the time (Mason, 1993; 411-423, 2002; 511-520). Morrison (1990) also identified nurse types; those who would pretend to be positive and therapeutic, but would actually be bullying and inconsiderate towards patients and be renowned for their superior ability to handle difficult patients. This is reminiscent of the argument that belief in incompetence in the patient increases the workers' status as caring and their ability to control (Goodley, 1998).

Obviously, there is a huge impact of nursing culture and nursing types on the delivery of care, and the studies cited by Mason were somewhat old. Each of these issues will be addressed next; nurse/patient relationships, the security-therapy paradox and positive aspects of caring in secure settings.

Nurse - Patient Relationships

*'The therapeutic relationship is the primary intervention within forensic mental health services and is founded upon a basis of trust, respect and the appropriate use of power'.
(Dale, 2001; 129)*

It appears paradoxical that therapeutic relationships can exist in forensic environments when nurses are responsible for security. Forensic settings are often described in negative terms as frightening and dangerous places. However they may also be described as places of care and compassion where the therapeutic nurse - patient relationship may thrive (Martin and Street, 2003). In the psychotherapy and counselling literature there appears to be a consensus that a friendly, warm relationship leads to positive therapeutic outcomes, despite the particular therapeutic models used (Hubble *et al*, 1999). Yet in forensic nursing this therapeutic relationship is complex and almost irreconcilable; where nurses struggle with the tensions between custody and care, security and therapy (Godin and Scanlon, 1997; Jones *et al*, 1999; Jenkins and Coffey, 2002).

The nurses surveyed in the UKCC and UCLAN (1999) study acknowledged the importance of developing relationships and supporting patients and this study found that of the nurses surveyed, over 95 percent agreed effective communication was an important part of their role – but nurses still viewed their powers as important.

Jenkins and Coffey (2002), surveyed 122 forensic community mental health nurses (FCNMN) in England, using a qualitative and quantitative postal questionnaire, and were especially interested in the issues concerning the building and maintaining of the therapeutic relationship when having to comply with restriction orders⁴⁷. With reference to the nurse - patient relationship, more than fifty percent of those surveyed believed the restriction orders⁴⁸ had little impact upon their relationships

⁴⁷ Fifty-two of those surveyed returned completed questionnaires and the majority of those were grade G or H nurses with 11-25 years of experience in nursing.

⁴⁸ Such orders may compel the user to engage with the nurse, because of the order rather than through choice.

with users. It appears that this power is used by some nurses in the survey to ensure engagement by a user and may benefit the relationship by forcing it to be maintained.

Further, physical security should be primarily provided by the building design and environment but the staff may still heavily influence the restrictions within secure settings (, 2001; 251-271). In fact, there should be a balance between physical security and relational security⁴⁹. The UKCC and UCLAN (1999) found that procedural and operational security had little evidence base or validation and, importantly, that nurses were excluded from their development and thus from their control.

Despite the complexities of this relationship, Jenkins and Coffey (2002) maintain that there is an intrinsic belief in the value of this relationship, as most nursing is based upon this bond. However, regarding this important relationship they also conclude that:

“...it seems (somewhat paradoxically) that nurses also hold a pragmatic belief in the value of having recourse to formal powers, should they become necessary”. (page 561)

That means that despite believing in the importance of the therapeutic relationship, nurses also valued compulsion; though the ethics of a relationship built upon forced compliance are questionable. Furthermore, Martin and Street (2003) were interested in how forensic nurses represent their patients and their relationship with them as illustrated in the nursing notes. They found that the nurses built⁵⁰ and maintained their ‘very powerful’ relationships through informal chats and through engaging the patients in various activities⁵¹, and the nursing notes entries reveal little of the nurse - patient relationship or the nursing assessments and care; but present mere snapshot episodes of activity without explanation or detail (Martin and Street, 2003; 546).

⁴⁹ Dale and Gardner, 2001 (251-271) report that relational security is the development of sound relationships between staff and patients to enable safe treatment without untoward incidents or the use of physical security. Procedural and operational security is derived from policy and procedure and governs the ways in which the patients are managed.

⁵⁰ These were similar findings to those of Robinson and Reed in 1996 (pp 68-88 and 118-119)

⁵¹ They used content analysis to study what nurses wrote about patients in an acute forensic nursing setting through sampling 1278 nursing entries in seventeen sets of patient notes. They also interviewed five experienced nurses.

What was acutely missing from the notes was offence related material: and researchers were told that offences were not referred to for two main reasons:

- to establish rapport with the patient
- to avoid nurses becoming judgemental.

Martin and Street argue that this failure to integrate the index offence into the relationship suggests that the nurses may have failed to practice holistically, as nursing interventions are not addressing the reasons for admission and appear paradoxical. They also note that, despite counselling and teaching being central to their role, the nurses merely referred to teaching patients briefly and used counselling skills as a means of behaviour management, rather than as a type of therapeutic intervention. They conclude by suggesting that the nurses they interviewed emphasised the importance of the therapeutic relationship, but the nursing notes did not reflect this view and suggested that the way in which nursing notes were constructed was indicative of a custodial culture. They consider two nuances of the word custodian, one referring to the security duties of the nurse and the other denoting a culture of the custodial manners of nursing staff which are irreconcilable with the nurse - patient relationship and therapeutic nursing care. Central to successful therapeutic relationships is the language used by nurses, the discourses that they create and perpetuate and what this means for their practice, and these are a central theme in this thesis.

Hamilton and Manias (2006) were interested in nurses' use of language and what that language produces in terms of their relationships and power. They view the use of language by nurses as a 'powerful tool' (page 85) in constructing their views of themselves and their views of other people⁵². Nursing is based traditionally on the medical model and nurses holding authority, and may be more so in forensic nursing (Scott, 2008). Hamilton and Manias (2006) suggest that there are several discourses used in nursing, some of which resist the dominant discourses and are referred to as marginal or subjugated discourses. Furthermore they refer to the Foucauldian idea of governmentality, which they define as the ways in which nurses use 'mechanisms of power' to create and maintain their behaviour (page 86). One such mechanism of governmentality is called 'normalising judgements' in which nurses create their normal and acceptable standards and then use

⁵² Their study is based on a review of the literature on nurses' language. They use a Foucauldian base for their critical analysis, being particularly interested in the discourses which nurses use that legitimise certain beliefs and actions. Thus their work is particularly relevant to this study.

strategies to exclude or correct behaviour which does not meet the normal standard. It is by these means that nurses can create and maintain views of themselves through language.

Hamilton and Manias (2006) use the example of a nurse who describes a patient as 'pleasant and interacting well' (page 87) and in doing so creates the view that s/he is competent to judge who and what is pleasant and what interacting well means, and at the same time creates a view that the patient is a person who should be observed and his/her behaviour examined. In this way the nurse's language constructs ideas and identities. Furthermore, the medical model and the power structures associated with it have been criticised by self-advocates:

*'The Lying Doctors
They write things down before you've even opened your mouth
They make their own minds up
They think they know about you without listening
They've got their own ideas about you
They make your decisions for you'.* (Portway Players, 1998, cited Docherty *et al*, 2005; 32; 27-50)

Clearly, professionals do not know everything about people with a learning disability and the judgmental and powerful attitudes found in the medical model continue to be criticised.

There is dominance in nursing language of medical, science and objectivity discourses. However, in studies of nurses' written language in the UK, Hamilton and Manias (2006) found that the nurses' written language was not standardised and related more to spoken English than written English and this is in opposition to the apparent professional view of nursing. Other writers suggest that this informal use of language is acknowledged by psychiatric nurses as deliberate to aid communication with patients. It may also indicate an attempt to resist the dominant medical discourse and create one that is nurse specific:

'Their use of non-standard and informal language reflects the nurses' resistance to the discourse of bioscience and, at best, reflects the distinctive and empathetic position in relation to patients in the midst of ethical strain associated with involuntary treatment. However, the requirements of the acute inpatient context mitigate against collaboration, in the language and practice of nursing'. (Hamilton and Manias, 2006; 91)

This indicates that nursing language may be subject to dominant discourses, policy and the environments in which they practice. This is of particular interest in forensic settings, where the dominance of certain discourses of security may subjugate others of care. Again, the theme of therapy versus Security is emerging as irreconcilable and one which the nurse resists.

The Therapy/Security Paradox

'The cloud of confusion that currently hangs over the field of forensic psychiatric nursing'.
(Morrison and Burnard, 1992, cited UKCC and UCLAN, 1999; 31)

The quotation above refers to the lack of role clarity which has traditionally dominated the forensic nursing literature. Central to this confusion are the difficulties in the interplay between patients and staff within secure environments, which have often remained unacknowledged in inquiries into forensic services (Duffy *et al*, 1997). This includes the necessity to attend to index offence behaviour, in order to manage risks whilst developing and maintaining non-judgemental and empathetic relationships with the patient – referred to as the security-therapy paradox⁵³. Nurses working in forensic environments have a unique working environment; they are viewed by the patients *'as being a source of treatment, comfort and advice'*, often over a number of years, and *'at the same time as part of the system that deprives them of their liberty'* (UKCC and UCLAN, 1999; 42). This is problematic for nurses as well as for those they care for and raises questions regarding appropriate use of their powers and restrictions (Chaloner, 1998). Although appearing as binary oppositions, care/therapy and custody/security can and do co-exist in forensic nursing (Paternelji-Taylor and Johnson, 1996). Indeed, maintaining security may be seen as an important part of the role and needs to be balanced with the therapeutic role of the nurse as custodial nursing practice has been shown to be related to poor quality care and has been highlighted in a number of inquiries and sensational reports⁵⁴.

By its nature, custodial care is the opposite to therapeutic, patient-centred nursing care⁵⁵ and is instead staff-centred and task oriented, based on observation, power and control, and where patients are considered to be problematic (Martin and Street, 2003). This security-therapy role conflict is also confused by the NMC Code of Professional Conduct (2002a), which states in the introduction that registered nurses must;

- Protect and support the health of the individual patients and clients.
- Protect and support the health of the wider community.

⁵³ Also referred to as the care/custody paradox.

⁵⁴ For example, Ashworth and The Special Hospitals Service Authority Service Report, 1993

⁵⁵ By care and therapy, here, I do not mean the controlling medicalised type of care historically associated with health professionals, but the aspirational and affirmative type of care which offers real choice and partnership in people's treatment (French and Swain, 2008, in Swain and French, 2008; 129-141).

- Act in such a way that justifies the trust and confidence the public have in you.

Nurses have a duty of care towards patients but also a duty of care towards the general public; sometimes a conflict in itself and although there is regular academic debate about security and therapy forensic nurses have to incorporate aspects of both to meet individual needs *and* maintain security (UKCC and UCLAN, 1999; 123-132).

Hamilton and Manias (2006) comment on the custodial role and its dominance in reviews of nursing notes. They suggest that this may be due to changing socio-political dominant management discourses which emphasise the importance of risk management and the efficacy of the patient journey to discharge, and may lead to nurses reporting the whereabouts and activities of patients for audit purposes rather than reporting their therapy, relationships and progress. Thus the nursing staff and their reporting activities may be subject to dominant discourses of management and industry which are passed down by funding bodies and policy, rather than reporting how they actually interact with the patient and reflect how they do their job.

The secure roles of nurses have been reported to lead to scepticism towards staff from patients, and from staff towards patients (Walsh, 2005). The patients may see the staff role conflict as not genuine, and genuineness is believed to be an important underlying attribute in nursing and is linked to concepts of integrity (Turnbull and Paterson, 1999; 99). The staff may mistrust patients that have a forensic history and assume that patients may exploit staff for their own ends. Walsh (1998) proposes that staff may be oriented towards either therapy or security, depending upon their own personal beliefs, experiences and culture. In a study of Canadian nurses, Phillips (1983) claimed that 17 percent of those surveyed considered their patients as criminals and not clients.

Forensic patients commonly share abusive dysfunctional relationships in their backgrounds and come to the therapeutic relationship willing to trust and share secrets; they expect the same from the staff who cannot give this investment as they require strict and clear boundaries in their relationships with patients to maintain acceptable conduct so as not to ruin the relationship or over-burden the patient with personal disclosure (Dale *et al*, 1999; 159-187; Dale, 2001; 127-139).

The ambiguity of the nurses' therapeutic and controlling roles was identified by Kitchener *et al* (1992), who suggest that nurses not capable of negotiating the complex issues involved may evade tackling the matter altogether. This means that nurses working in such environments may require significant continuing development and training, as well as effective supervision (UKCC and UCLAN, 1999; 182-201). Indeed, the security-therapy balance was stated to be the most consistently reported dilemma for nurses in secure settings. Despite this, there are many aspects of the nursing profession which may be considered as positive (UKCC and UCLAN, 1999; 14 - 34).

Positive Aspects of Caring

Whilst it is well acknowledged in the literature that caring for people with complex needs may be stressful, it is rarely acknowledged that it also brings its own rewards (Grant *et al*, 1998; xvii-xix). These rewards have more recently been described in terms of the carers enjoying the achievements of the person with a learning disability and enjoying the intrapersonal aspects of the caring role (Grant *et al*, 1998; xvii-xix). Williams and Dale (2001) describe six professional values common to mental health nursing and relevant to forensic practice: respect; a belief that everyone deserves treatment; a non-judgmental approach; application of ethical quality care despite the index offence or popularity of the patient; being fair to all patients; and maintenance of confidentiality. It is such nursing values that lead to sound relationships that encourage patients to become self-reliant and are the main purpose of treatment and central to health policy (Scott, 2006). Many nurses describe the best part of their role as their interactions with patients. In addition, there are aspects of the nurse, some reported by patients, which it appears enable nurses to do their jobs well. In the literature, these are referred to as good nurse characteristics.

Characteristics of the “Good Nurse”

There remain many opinions as to what good nursing characteristics are, but most commentators agree that their characteristics should involve: a knowledge base; a certain level of understanding and skill; a good education and a range of personal attitudes and moral or ethical traits⁵⁶. Therefore, the competent nurse is more than a qualified and experienced nurse; it seems something else is required for the nurse to use her knowledge and skill with competence, and this ‘something else’ relates to the nurse’s personal characteristics. Smith and Godfrey (2002) carried out a qualitative study to answer the question ‘*who is the good nurse and how does he/she go about doing the right thing?*’ (page 304)⁵⁷. Seven main categories emerged from the data: personal characteristics; professional characteristics; knowledge base; patient centeredness; advocacy; critical thinking; and patient care. Although the study was small with some limitations, the authors found that most of the nurses in the study reported a strong connection between being a good nurse and doing the right thing, suggesting a link between not only knowledge and skill and the doing of nursing, but also with the virtues and character of nurses themselves (Smith and Godfrey, 2002).

Similarly, Bjorkstrom *et al* (2006) asked student nurses in Sweden to define a good nurse and the bad nurse and found that the good nurse was described in four main categories: doing good for others; being competent and skilled; having professional courage and pride; and seeking professional development. The category of doing good for others was the most frequently reported category and included concepts like warmth and liking people, being tolerant, fair, interested, motivated and cheerful, and displaying a positive outlook on life. The idea of being a good nurse is also intrinsically linked to the ideas of caring and ethics in nursing practice; as Levine (1977) suggests:

‘Ethical behaviour is not the display of one’s moral rectitude in times of crisis. It is the day to day expression of one’s commitment to other persons and the way in which human beings relate to one another in their daily interactions.’ (page 846)

This is a topic discussed extensively in nursing, where ethical practice includes seeing patients as the same as you and therefore displaying empathy in interaction and nursing practice (Scott, 2006). It has been linked to the personal characteristics of nurses and describes those characteristics demonstrated by nurses by virtue of who they are, and can be displayed in their everyday interactions

⁵⁶ As described in: Smith and Godfrey, 2002; Bjorkstrom *et al*, 2006; Lofmark, 2006; Scott, 2008

⁵⁷ Fifty-three American registered nurses replied to their questionnaire. They used content analysis to analyse the data.

with others (Smith and Godfrey, 2002; Varcoe *et al*, 2004). Nurses who display characteristics of caring and compassion, with respect for others and the virtue of honesty, exhibit characteristics similar to those defined as core nursing values (Turnbull and Paterson, 1999; 99). Smith and Godfrey (2002) found that almost a third of the answers to the 'who is the good nurse?' question were categorised as personal characteristics. These personal characteristics include: having integrity and being pleasant; committed; understanding; conscientious; genuine and honest; and showing common sense and kindness (Wilson and Startup, 1991; Smith and Godfrey, 2002; Scott, 2006). They state that:

'Ethical nursing is embedded in the wholeness of each person as he or she becomes the good nurse by doing the right thing'. (Smith and Godfrey, 2002; 309)

Chaloner (1998) lists five ethical issues for forensic nurses: power and control; risk assessment and judging dangerousness; consent to treatment; confidentiality; and dealing with difficult or unpopular patients. Dale and Gardner (2001; 251-271) suggest that whilst there are no easy answers to such issues, ethical consideration of the situation and the code of conduct help nurses fully to appraise the situation. Good nurses may do more than increase the satisfaction of patients' experiences. They may make their interactions run more smoothly through attractive personal characteristics - patients need to develop a trusting relationship with the nurse which aid in treatments - and they may be encouraged by nurses displaying good personal characteristics, such as compassion, which are then picked up by the patient (Scott, 2006). Indeed, it seems necessary for nurses to demonstrate "good" nursing characteristics to enable them to use their skills, knowledge and experience to become a competent nurse (Lofmark, 2006).

Reed *et al* (2007) included specialist nurses working with people with a learning disability in their national survey. In describing such 'good' characteristics they stated that they included being '*very knowledgeable about people with complex needs*' (page 373)⁵⁸, and used examples of knowing how to care for people with challenging behaviours as important. The staff in this study were described as having knowledge, experience and a patience founded on understanding of the particular needs of this group.

⁵⁸ Complex needs, here, meaning working in a forensic environment

For this group of people the staff were said:

'to be able to cut through the 'fog' and function as a logical, sensible, caring practitioner, as a consequence of having a 'caring way'. (Page 373)

Of particular note to Reed *et al* (2007) is how much the staff loved their job and believed that commitment was a crucial characteristic, as well as:

- empathy
- compassion
- a certain 'warmness'
- non-judgmental attitude
- staff being mindful of the service user's complex history to assess risks
- risk being managed in a humane and caring way

These are similar to those discussed by Dale (2001) regarding therapeutic relationships in secure settings:

'It sounds funny to say that not everybody is suited to being an [older people's] Nurse (in a forensic setting) because when you look at the job and you look at it on paper anybody can do it... on paper... but not everybody can do it. There has got to be that, that little something else.' (In brackets, my addition - Reed *et al*, 2007; 373)

It appears difficult to capture this 'little something else', but it seems that it is not to do with specific knowledge or skill, but to do with personal attributes like warmness, ethical practice and enjoying the role, with a will to do a good job.

However, this is in stark contrast to the nurses in Jenkins and Coffey's study (2002) who believed strongly in the therapeutic relationship, but paradoxically valued the ability to compel the patients to interact with therapy and follow rules. This is a central theme and paradox which is returned to in Chapter 8 of this thesis. There are claims that the nurse's caring role is a 'false consciousness' (Dingwall and Allen, 2001, cited in Scott, 2008; 241) or myth, as caring is increasingly carried out by unqualified staff as nurses' professionalism increases and the emotional part of the role decreases (Scott, 2007). This subjugation of the caring role in practice has implications for the therapeutic relationship. It also effects nurse education and the nurses' ability to enhance holistic care. It implies that increased attention may have to be paid to the preparation of unqualified nursing staff to enhance the workforce and ensure the development of practice which affects the patient positively (DoH

2008b; Scott, 2008). Furthermore, professionals' view of their own good traits is not always equated with the experiences of those they care for:

'[There are] two very strong and persistent themes [in disabled people's experiences of healthcare]. The first is that disabled people do not necessarily believe that medical treatment and what it might achieve is the most important thing within their lives. A second theme relates to the lack of power disabled people have over their lives...'
(French and Swain, 2008; 86).

Such issues will be addressed in the Results and Discussion Chapters.

Summary

This chapter has examined the role of policy and culture in forensic settings with particular reference to nursing staff. These and other issues influence the way nurses practice in this unique environment, where nursing staff, paradoxically, have to adhere to security concerns *and* care for the patients (see Figure 1: Influences in Forensic Nursing). The therapeutic relationship has been examined with reference to its importance; and an examination of ideas about what makes a good nurse found that personal attributes and communication skills appear key in the literature, together with a certain warmth and approachability.

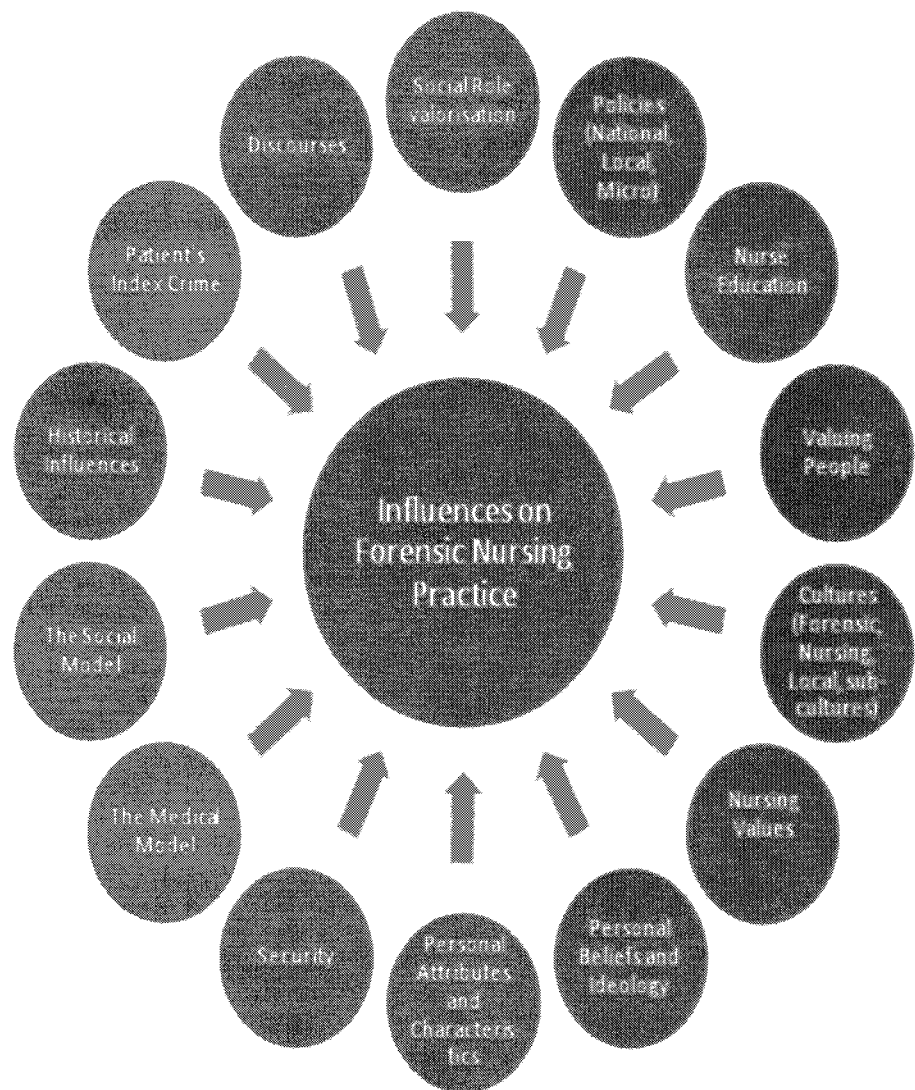


Figure 1: Influences on Forensic Nursing

Chapter 5 – Methods of Analysis

Choice of Theoretical Components

My interest in this project began, as a practicing nurse and nurse educator, with the observation that the ideologies upon which most nursing of people with learning disabilities is based may not always be effective in practice or relevant to the lives of people with a learning disability. Despite great strides being taken in the disability movement's theoretical and ideological base, a suitable alternative to these models has not been undertaken by the profession and nurse education, policy and practice is still heavily embedded in them (Thompson, 1997). Therefore, macro models associated with disability are central to this thesis.

Through my teaching, research and practice I began to reflect on possible ideologies and their impacts upon nursing practice, and ultimately the lives of people involved. An effective way to explore ideology is through discourse – as such critical discourse analysis (CDA) is key to the investigation. Ideology is difficult to study, therefore, by exploring the interpretive repertoires paradoxes may be exposed – showing difficulties and inconsistencies in the discourses. The explanations and justifications for such inconsistencies in discourses are called practical ideologies; and these highlight the ideologies underpinning the discourses regarding forensic practice. Importantly this study considers the discourses of the men and staff and, as such, is constructive in exploring unique areas of nursing care.

Forensic practice is a relatively new discipline in nursing people with learning disabilities and the men and the staff are stigmatised. As I set out to expose positive discourses about people with a learning disability, I will show that there are many attributes held by the people in this study. I argue that if it is possible to expose such attributes in people living in secure settings, then it should be possible to expose positive characteristics, abilities and attributes held by people with a learning disability living anywhere.

Therefore, the proposition that difference is positive is fundamental to this thesis. Ideas about nurses working in forensic settings are often negative, yet the therapeutic relationship is vital to good patient

outcomes. Therefore it is important that I explore good relationships and nursing practice (apparently) paradoxically within secure settings.

Aims of the study

CDA is a method used to unearth such ideologies so that they may be exposed and studied.

Therefore the aims of this study are to:

1. Take a critical and a post-modern approach to investigating given “truths” about the positives of having a learning disability; men with a learning disability who offend; and forensic nursing.
2. Apply critical discourse analysis to examine micro-discourses and the macro-models associated with having a learning disability; national and local policy; and nursing and disability models, giving a socio-political overview.
3. Combine the discourse analysis of aims 1 and 2 to expose discourse, repertoires, paradoxes and practical ideologies which justify treatment on the MSU and expose the ideologies and beliefs about the implications of having a learning disability in this setting.

Research Approach

Critical theorists reject the idea that research is value free, but view it as a political act. It is not merely research for the sake of knowledge, but is geared to social and/or political change and questions reality, power and knowledge, and how this affects people (May, 200; 15-27; Guba 1990; Schwandt, 1997). The importance of the author in the analysis in qualitative research is acknowledged (Popkewitz, 1990), and the preface begins with positioning the author so the critical stance that I take and the constructions I make of the data are transparent.

It is important that the analyst has some cultural competency and political savvy before choosing discourse analysis (DA) as his/her method. I have the cultural, political and social awareness in forensic practice from my practice, academic and research background to enable me to understand the data and be realistic about what was going on (Parker and Burman 1993). The broad methodological stance chosen for this study discussed in Chapter 2 explores the links between the

conceptual frameworks and explains and defends the methodological approach. It discusses Foucault's methodology which was used to analyse and criticise similar social problems. He viewed communications as discourses which informed institutions that constitute the power in our society (Fairclough, 2001). It is upon this vision of discourse that DA, and particularly CDA, have been used as a theoretical basis. Foucault believed that the elements of discourse are the substance of ideology, and all use of language is viewed as ideological. He used criticism to unearth subjugated knowledge and challenge official and accepted accounts of the truth. Similarly this study unearths the discourses surrounding forensic practice and challenges the constructions of accepted truths about the MSU, the men who live there and nursing practice.

Foucault is essential reading for anyone wishing to investigate discourse, especially when the subject is a social problem. Reading Foucault and a study of the macro discourses associated with learning disability was a starting point to visualise and explain what it was I wished to investigate i.e. the ideologies underpinning forensic practice. In order to explore ideologies it was essential to use discourse. Upon exploring CDA, I discovered the work of Fairclough (2001), Potter and Wetherell (1987) and Burman and Parker (1993) who explained the methodology and methods of CDA. As it was specifically the ideologies I would uncover, the specific methods used in analysis are interpretive repertoires and practical ideologies discussed by Marshal and Raabe (1993) and Gill (1993) respectively.

The chapter now turns to explore CDA before describing the study's design, data, sample and method of analysis.

Discourse Analysis

Historically, science had looked at what we do – then in 1980s there was a shift in thinking, which was termed the ‘Turn to Language’⁵⁹. DA is about how events are constructed through talk in the social world; language helps us to know who we are as humans, and reproduces cultural identity as people draw upon shared meanings (Burman and Parker, 1993; 1-3; Wood and Kroger, 2000; 3-17). This shift demonstrates a recognition of what is ‘uniquely human’ - the cultural, instead of the biological, view of human nature (Wood and Kroger, 2000; x). A cultural view of human nature may be particularly important in the study of discourses surrounding people with a learning disability. Models of disability have not historically incorporated them in the social construction of disability, but have commonly continued to define them in terms of naturalisation, when clearly learning disability can be considered as socially constructed too.

Behaviour is seen as a form of communication – the transmission of a message and, as such, it includes feelings, beliefs, attitudes and ideologies (Wood and Kroger, 2000; 3-17). DA is about the action, function and structure of talk, as discourse contains and reinforces ideology (Burman and Parker, 1993; 1-3). Burman and Parker discuss three types of discourses that have been studied in the field of social psychology; discourse, repertoires and practical ideologies. Discourses are implied social relations which show how language does not merely reflect what it sees but helps to construct meanings. Meanings, therefore, are not fixed and are multiple (Burman and Parker, 1993; Parker and Burman, 1993). Repertoires are something like linguistic schemas, as they are borrowed language which we do not invent each time we speak but ‘refashion’ to suit our own purposes (Burman and Parker, 1993; 3; Marshal and Raabe, 1993). Practical ideologies are repertoires which include or exclude people:

“...attention to the multiple and contradictory reasons people give for their prejudice allows a better understanding of ideology than of simple delusion or fixed ideas” (Burman and Parker, 1993; 4, Gill, 1993)

Both are keys to the CDA of this thesis and provide the conceptual framework to design research and analyse findings.

⁵⁹ This is when the emphasis shifts from looking at talk to explain behaviour, to looking at talk as the behaviour itself.

Critical Discourse Analysis

Critical discourse analysis (CDA) begins with the premise of social problems, and unlike other types of discourse the starting point is not text or talk, but social issues (Fairclough, 2001). CDA does not differ so much in analysis from other forms of DA, except that the researcher begins the research with some prior theory of dominance or power (Talk and Text, 2006). Researchers then set out to find texts in which it can be demonstrated that this discourse supports one group's dominance over another or show how this power may be challenged through exposing the discourses used and, as such fits, perfectly with this thesis and with Foucauldian ideas (Talk and Text, 2006). This thesis begins with the premise that learning disabilities and nursing practice are dominated by macro and unsuitable (even negative) discourses which affect the staff and the men in the MSU. CDA will unearth the ideologies which enable the maintenance and use of such discourses and call them into question through exposing the paradoxes within such discourses and, therefore, question the justifications for forensic practice.

CDA is not merely concerned with language, but how it works within issues of power, ideologies and personal and social identities, and is critical in the sense that it is linked to social change and emancipation. Discourses are ways of using language and these language bites (words, phrases, expressions, etc.) that people use are the "material of ideology" (Fairclough, 2001; 233). Post-structuralist (or post-modern) approaches are about deconstructing given 'truths' about the social world (Burman and Parker, 1993; 1-3) and are *'suspicious, both of claims to reveal a world outside of language and of claims that we can experience any aspects of ourselves outside language'* whilst also being committed to *'the socially constructed nature of reality, or the socially constructed reality of nature'* (Burman and Parker, 1993; 3, 4 and 5). These approaches are concerned with how objects (for example offenders with a learning disability) and subjects (how we experience the world) are constructed (Burman and Parker, 1993).

Interpretive Repertoires

Interpretive repertoires (IR) are used for some types of CDA and were developed originally in social psychology but are now used in other disciplines including health and management (McKenzie, 2006). CDA views *'language and people as separate entities, and that language is a neutral medium between the social actor and the world'* (McKenzie, 2006; 1) CDA sees the accounts people have of themselves or of their world as indicators of basic processes. Interpretive repertoires help to expose such processes and are defined as *'recurrent patterns in the linguistic constructions'* (Marshall and Raabe, 1993; 34)⁶⁰. Unlike macro-discourses, these repertoires are small, which means that people have more repertoires to draw upon when speaking (Edgley, 2001). Similarities are important as, although people's representation of themselves changes over time and across different situations and issues, within these different accounts are consistent schemas which are called IRs (Marshall and Raabe, 1993). The language that we use to describe issues or events is taken from a 'pre-existing pool' (Marshall and Raabe, 1993; 34). CDA examines this pool and how it is used by participants.

Each IR is built using a finite range of terms which are similar in style and grammar (McKenzie, 2006; Marshall and Raabe, 1993). They show how people construct their language to appear accurate⁶¹ or demonstrate how people use language to serve functions⁶² (McKenzie, 2006). In analysing IRs the researcher looks for terms, phrases and metaphors used in the participant's language in terms of resemblance in their content and structure, but also searching for variability (Marshall and Raabe, 1993). The discourse forming the central focus of this study concerns the social relationships implicit in conversational terms used by staff and men working together on a research study. The study explores ideologies underpinning these terms and the actions which the resultant discourse legitimates (McNaughton, 1993).

⁶⁰ Therefore, it does some of the same work as post-structuralist types of DA where people are viewed as encultured into specific ways of interpreting and understanding their world, which are particularly attached to concepts of ideology (Egley, 2001).

⁶¹ The epistemological orientation of discourse.

⁶² The action orientation of discourse.

Practical Ideologies

The term practical ideologies (PI) was defined by Wetherell in 1987 as IRs which exclude certain people or groups of people (Gill, 1993). They are discourses which justify prejudice through making them plausible, often described in non-prejudicial terms and use values such as justice and equality, or lay the blame for the prejudice elsewhere (often at the feet of those for whom prejudice occurs) (Gill, 1993). We all have a range of explanations and justifications for our actions and beliefs to draw upon. Therefore, often these PIs can be similar and inconsistent within and between participants (Gill, 1993). It is important to look at not only what people say, but to look at what they say in terms of its discursive functions, as DA is a '*systematic approach to the evaluation of texts whose findings are open to interpretation*' and we may see the ideological effects of the PIs in the discourses or arguments used, which may perpetuate inequality, power, control, etc. (Gill, 1993; 87).

Gill (1993) suggests that discourse *is* ideological if it justifies and perpetuates an ideology. DA presents a way of understanding ideology by analysing the way that we use discourse⁶³, often in similar ways, to '*...naturalise, reify or legitimise*' inequality or power imbalance in society (Gill, 1993; 87).

Williams (2000) questions the general ability to interpret our own or other's everyday social practices; something he calls the '*mundane intelligibility of social life*' (page 82). He suggests that it is essential that enough information about the utterances is given, so that the reader might have faith in the quality and the validity of the researcher's interpretations. Researchers using DA do not normally disclose the frequency of the terms in the data and the reiteration of the terms to the participants can be harmful and become navel gazing at best, and may mean the researcher's interpretations are denied at worst (Widdicombe, 1993; Parker and Burman, 1993; Williams, 2000)⁶⁴.

⁶³ There are many criticisms of academics' interpretations of others' opinions. In this study I interpret, as well as analyse, the discourses of others and myself (Williams, 2000). During this interpretation I integrate quotations from the participants and texts and interpret their possible functions and underlying assumptions and ideologies. I do not claim to 'know' the functions of others' use of language, but to interpret possible functions of the discourses that are employed.

⁶⁴ I decided not to return to the men with my interpretations of the data for checking by them, for the reasons outlined in the above text and a responsibility that I felt. The men may have become disconcerted by any interpretations that I have regarding criticism of their treatment, yet would also feel powerless to change anything about their treatment too; thus I may have been leaving them discontented and with no hope of emancipation from their current status. Similarly, I did not ask the staff, as I felt it would appear that I had further excluded the men from the research process. None of the men have requested copies of the report, and I have prepared accessible versions of an executive summary in case requested.

Design Selection

The design of the research was limited because of the retrospective nature of the data⁶⁵. In participative action research every member of the group has an equitable say. Therefore, the LS intended that all of the participants had equal weight as researchers. The participants included researchers, who were employed to carry out the research, staff who work in the secure unit and the men who live in the secure unit, who all acted as co-researchers for the LS.

Sample

Participating in the LS were five qualified nurses and five unqualified nursing staff who work with the men as outlined in Chapter 1. The staff are not described in detail as they could not attend workshops every week, and their involvement during workshops did not match the intensity of the men. For this reason I did not build the same level of relationship with the staff as with the men, and felt it would not be prudent to describe them in detail. The qualified staff are registered nurses (RNLDs) identified as staff numbers; 2, 6, 7, 9 and 10. The remaining staff are health care assistants.

The relationship between the respondents, the research design and the conceptual framework is a complex one. A great deal has been written, discussed and decided about learning disabilities, but the difficulty is that this discussion occurs, mostly, with people who do not have a learning disability and, occasionally, with those with milder forms of learning disabilities who cannot truly represent those who may have more or different needs (Valuing People, 2001). Therefore, those who are less able to speak up for themselves, those with complex needs, rarely find a voice. Their stories, thoughts and dreams are not often heard. Northway (2000b) discussed the involvement of people with a learning disability in research and how traditionally people with a learning disability have not been directly involved in carrying out research. Recent moves towards 'participatory' research have shown that people with a learning disability make a valuable contribution to research. Knox *et al* (2000) stated that research should go further than merely being participatory, but should be

⁶⁵ The data in this thesis are based upon a retrospective analysis of a Local Study of Facilitative Participative Action Research which took place over twenty months in a secure setting. The Local Study (LS) was entitled - *Understanding research, consent and ethics: a participatory research methodology in a medium secure unit for men with a learning disability*. A description and purpose and aims of the LS can be found in Appendix 3

emancipatory. People with a learning disability should be asking the research questions as they should know what is important and are now beginning to be seen as the “experts” in their own disability and not merely the subjects of our research (Knox *et al*, 2000; Northway, 2000b).

Kitchin (2000) states that this traditional exclusion of disabled people from research is basically ‘*flawed*’ (page 26); it is carried out predominantly by non-disabled people, and based around their agendas, instead of those of disabled people. Research is often described as researcher-orientated, which is ‘*alienating and disempowers and disenfranchises*’ disabled people from the research, thus mirroring and compounding the power relationships and oppression of disabled people; it is the exploitation of disabled people by academics for their own academic prowess (*ibid*). It is important, therefore, to enable the men’s opinions to be heard in this study. Even though they could not be co-researchers in this thesis, their being co-researchers in the LS (despite their multiple stigmas, their disability and status under the Mental Health Act), gave them the confidence and opportunity to speak out. It enabled authentic involvement in research and relationships of collaboration which form the data for this thesis and are the tools to explore the ideologies, beliefs and tensions that exist in forensic practice.

This study analyses the discourses affecting them and the staff who work with them to unearth ideologies. The use of the retrospective data has advantages here, as it would be difficult to articulate one’s own ideologies. The analysis chosen enabled me to unearth ideologies through the conversational style of the retrospective data. Whilst the study uses retrospective data, it is important to note that discourses are not particularly static or universal. By their nature they illustrate multiple truths and are transformative and ever-changing (Parker and Burman, 1993).

Data Sources

The data sources used in this project are of two distinct types; oral (transcribed as textual data) and written (secondary textual data). The oral data are in the form of taped interviews⁶⁶ and activities taking place in group sessions^{67 68} which were taped and transcribed. The written discourse will take the form of publications, and includes legislation and policy documents⁶⁹. Interviews within DA are considered interactions as much as any other conversation; and the more open-ended questions that are asked, the more this is emphasised (Wood and Kroger, 2000; 18-33 and 55-81). The interviews in this study were semi-structured and used open-ended questions for the baseline interviews and a narrative approach for the second round of interviews. The interviews all took place within a room in the medium secure unit (MSU). The staff interviews included the researcher and the members of staff; the men's interviews included the researcher, the men and one other⁷⁰.

The recording of material may affect the use of language and actions, and how much this will occur is difficult to estimate, as although the participants gave permission to be tape-recorded, this took place over hours of conversations and group work. Therefore, it is difficult to tell whether they forgot about the tape and engaged 'naturally' in conversation or not (Fairclough, 2001). Fidelity is important for the data used for DA. The tapes were transcribed carefully, as it is not merely the text that is analysed but the spoken language in action that DA is concerned with here. The transcriptions were carried out by a research assistant. I used the original transcriptions as a baseline and began a transcription process appropriate for DA. I had already analysed the transcriptions for other purposes and, therefore, had a good idea of what the texts contained and identified the specific focus and appropriate sections for analysis. The tapes were listened to and read simultaneously to aid DA transcription and 'get a feel' for the data.

⁶⁶ Most participants were interviewed twice and the interview schedules can be found in Appendix 4.

⁶⁷ There were eight workshops and a description of each may be found in Appendix 5

⁶⁸ There was an initial staff session and a staff focus group which – details of each may be found in Appendices 6 and 7 respectively.

⁶⁹ The secondary textual data included MSU policies and Valuing People (DoH, 2001). The local policies were provided by the NHS Trust and used along with pertinent abstracts from Valuing People (DoH, 2001).

⁷⁰ Security dictated that the researchers were not able to be alone with the men for interview, but it was felt that the interviews may have been affected if staff were present, so a compromise was reached where a colleague joined the interviews - he was considered a member of staff, as far as security was concerned, but did not work primarily within the Trust and not ever within the medium secure unit. The men were asked for their permission for the colleague to be present and all agreed. However, some of the men knew him from previous work with them, as a practising nurse, and therefore just how much they viewed him as a staff member is debatable.

The sessions and focus groups took place within the MSU within a large communal dining room. The staff session took place in the Board Room of the MSU. All participants were given an A4 book to note down comments about the workshops and record their thoughts and feelings. These are referred to as diaries in the study. As the project progressed, the five men who continued used these extensively. The researchers also kept such diaries which are referred to as researcher's notes. The secondary textual data were transferred into rich text and entered into NVivo (QSR NVivo v. 2.0 for Windows 2000, XP and ME) along with the data collected through events and analysed in a similar way.

Participants and Sample

Sample size is not an issue of validity in DA, as it is in quantitative studies. The sample size in DA is not about the number of participants and the generalisability, but about the number of discursive utterances and the language that is used; they are not supposed to afford generalisations or approximations of population values, but offer specific examples which demonstrate depth of analysis (Wood and Kroger, 2000; 55-68 and 163-192). The sample in this study consisted of two paid researchers (including the author) and one MSc Student researcher, seven men researchers and ten staff researchers. The men (after extensive discussions and information in accessible formats⁷¹) and staff gave permission for the data to be used retrospectively for this thesis, and were fully aware of the nature of the analysis⁷². Data were collected in a number of ways during the LS, including baseline and follow-up interviews, workshops, diaries, research field notes and a focus group with the staff, resulting in 52 transcriptions for analysis, some of hours in length⁷³.

⁷¹ Please find the accessible consent forms in Appendix 8

⁷² One man subsequently withdrew this permission and his abstracts have been duly removed.

⁷³ Please see Appendix 3 for a description of the LS, its purpose and aims. Please see Appendices 4, 5, 6 and 7, respectively, for details of the interviews, workshops, initial staff session and focus groups. The researcher interviews were developed and carried out by the men and the schedule may be found in Appendix 9.

Type of Data collection event	Number of Transcriptions
Group Workshops	8
Interview 1 -Men	7
Interview 2 -Men	5
Interview 1 – Staff	7
Interviews 2 – Staff	5
Interview - Researchers	2
Staff Focus Group	1
Staff Workshop	1
Diaries and researcher field notes	17
Total	53

Table 1 – Data Collection Events

The LS began by recruiting two paid research staff (and an MSc student who participated for a period of six months). The staff from the MSU were approached during a training session and eight initially agreed to take part, but subsequently two more staff were recruited. The staff then approached the men and seven men agreed to take part. However, one man has been transferred and one man withdrew.

Participant	Number	Withdrawn	Additions	Total
Researcher	3	1	0	2
Men	7	2	0	5
Staff	8	0	2	10
Total	18	3	2	17

Table 2 - Participants

The texts which were analysed included:

1. Valuing People.
2. Local policies:
 - i. Operational Policy
 - ii. Admissions Policy
 - iii. Sexual Relationships Policy
 - iv. Seclusion Policy

The LS and consequently this thesis, is limited in that it is a local study of a specific group of men in a specialised MSU which took place at a particular time. Therefore only limited generalisation to similar populations and practice may be warranted.

Data Analysis

Wolcott (1990; 50) reminds us of Agar (1980; 9) who described analysis as:

'You learn something ("collect some data"), then you try to make sense out of it ("analysis"), then you go back and see if the interpretation makes sense in light of new experience ("collect more data"), then you refine your interpretation ("more analysis"), and so on. The process is dialectic, not linear.'

There is no recipe for doing DA; certain steps have been suggested by writers, but for the initial analysis I have followed the stages of CDA suggested by Fairclough (2001) to enable a systematic preliminary analysis of the data (Potter and Wetherell, 1987; 158-176; Wolcott, 1990; 9-44). The transcribed data from the interviews and workshops were analysed using QSR NVivo v. 2.0 for Windows 2000, XP and ME, and the coding and thematic analysis was produced by a critical review of current models and my engagement in the data - each process of writing, analysing and interpreting data informs the other. NVIVO assists in the storage, retrieval and focused contextualised searches of the large amounts of data being collected.

The analytic framework resulted from my experience of the data and the literature⁷⁴. Categories and codes also emerged from the data themselves. In NVivo, this is referred to as creating a node '*in vivo*', and is regarded as significant as it is taken from the participant's own words and thus considered closer to the material that is being studied (Flick, 2006; 342-356). The transcriptions from data collection events were scanned for pertinent phrases, themes and words related to ideas defined in the nodes⁷⁵. Coding data is related to, but is not in itself, data analysis; it is a practical heuristic approach to understanding data (Coffey *et al*, 1996). Data analysis is the engagement of the researcher with the data throughout the research process - in this case the data analysis moved through several phrases⁷⁶.

The data were classified into segments, categorised and separated, then put together to create meaning (Flick, 2006; 295-319) through line by line coding - segments of data with shared meaning which, in this case, were most often phrases or whole sections were placed into nodes which mark such distinct chunks of data (*ibid*). The data were then coded, which consisted of identifying and recording text related to similar concepts and ideas, sorted and combined using a coding system collecting data under thematic headings. These were then compared, contrasted and categories sorted into key themes. Codes are attached to segments of data and used as labels, stressing what that section of data represented. In NVivo the text is coded at a node which connects related parts of text.

Whilst analysing line by line I considered the following, developed from Wood and Kroger (2000, pages 91-95):

- Consider your reaction to the text
- Take note of the obvious, what is going on?
- Note that:
- Not everything is literal.
- What is not there, for example, silence, pause or absence of a greeting?

⁷⁴ Not only was I present at all of the workshops and focus groups and most interviews, I had already analysed the data in a different way for the LS so I was very familiar with the data before using DA, and so had already formulated important groupings.

⁷⁵ NVivo supports the search for appropriate words and phrases or paragraphs in the context in which they were used. However NVivo is a data handling software, the data analysis and interpretation is still the job of the researcher.

⁷⁶ Please see Appendix 10 for a pictorial representation of the data analysis process.

- How the text is structured as this may indicate what is important to the speaker.
- Note that there may be several functions for discourse.
- Analyse how participants categorise.
- Identify assumptions in the text, such as gender, disability, etc.
- I have insider knowledge as a member of that culture as a nurse which may be an advantage.
- Be interpretive.

The data were trawled systematically several times and the appropriate text was sorted into categories. This process of analysis and interpreting the data included open coding, which then became more selective towards the end of the process and this is referred to as focussed coding (Flick, 2006). DA does not lend itself so easily to mechanical methods as other forms of analysis. DA has:

'No analytic method... Rather there is a broad theoretical framework, which focuses attention on the constructive and functional dimensions of discourse, coupled with the reader's skill in identifying patterns of consistency and variation'. (Potter and Wetherell, 1987; 169)

The literature is concerned only with general steps in analysis that should be considered when carrying out DA. Probably the most influential writers on the subject of how to carry out DA are Potter and Wetherell (1987) and, although nearly twenty years old, their work still impacts upon how DA is done today. They suggest certain steps to carrying out DA.

Initially I coded by doing a first run-through of the transcriptions looking for what is interesting and carrying out provisional coding; ignoring nothing, looking for features and consistency and variability in the text. I then re-analysed looking for repertoires, practical ideologies and discourses. NVivo aided in the analysis of connections between the nodes through enabling subsequent searches among the nodes for specific text and enabling tracking such related text through thematic codes. For example, I was able to follow ideas of relationships that the staff had through to the ideas that the men had of the same relationships, so that the data were confirmed and triangulated. Throughout subsequent trawls of the data it was obvious that the original nodes were inadequate and needed to be further coded and refined into categories. For example, ideas regarding the men were often distinct from ideas of what learning disabilities was viewed as; therefore, these nodes had to be discreet and recoded as separate when appropriate. Such nodes were then grouped around broad

phenomena which were relevant to the study; those which made comparisons about the phenomena being studied are called “tree nodes” within NVivo (Strauss and Corbin, 1990 cited in Flick, 2006; 295-319). The data were organised into a tree and branches type taxonomy (Prior. L in Silverman, 2004). In NVivo the branch codes are referred to as “child nodes”. For example the tree node ‘description of men’ has several child nodes which hold discreet categories of that tree node such as: ‘self description of men; the best thing about the men; the men's attributes’, etc. The final list of nodes which was used in the analysis is outlined in Appendix 11.

Also of interest to the analysis was who had said what, in which context and to what purpose. NVivo enables the researcher to trace text through the data and note such issues, thus enabling the researcher to check the context of the quotations that they are highlighting and aiding the interpretation of text (Wolcott, 1990; 45-64). Naturally, some of the text appeared relevant to more than one theme. Any such data were eventually used in the most appropriate way for the analysis – all text used in the results was judged to be the most appropriate or accurate expression of that IR, PI or paradox.

Searches sought answers to my general research questions outlined in the Preface:

What are the discourses related to learning disability and forensic practice?

What are the positive discourses?

What ideologies underpin and justify forensic practice?

I searched for interpretive repertoires by scrutinising the data for terms, phrases and metaphors, i.e. main repertoires. I then examined similarities in content and structure of these as well as any variability, firstly using extracts that appeared even vaguely associated to develop the repertoire list⁷⁷. It was then important to look at how the language is being used and whether they have the same function(s) and to check the relationship of the repertoires to the concepts I was interested in, for example: ‘power and security’. It was important now to think about:

- Where these repertoires come from?
- Which are used the most?
- *Why* they are used the most?

⁷⁷ A full list of the original appropriate repertoires found may be found in Appendix 12. Please note that the repertoire names have been refined since this list was completed and may appear, but named differently, in the results.

- What about the repertoires which are *not* used?

These questions highlight issues of power concerning which agencies control the discourses we use: for example, governmental, other political or media agencies⁷⁸.

The interpretive repertoires revealed paradoxes in the data; for each repertoire there were opposing repertoires in use and here they are called paradoxes. These illustrate similarities and variability in these repertoires and their use and function in forensic learning disability practice. Those repertoires which are most common are used as examples as well as those which suitably demonstrate the paradoxes (Marshall and Raabe, 1993).

It was the repertoires involved in such paradoxes which were of interest for this thesis, as this meant that there were inconsistencies in the beliefs about forensic practice involving people with a learning disability⁷⁹. Further analyses of the paradoxes illustrate the practical ideologies or the arguments which justify certain practices. To analyse and interpret the data for practical ideologies, I looked for broad accounts and the particular claims of that PI. Gill (1993) suggests that sometimes stories may be constructed around such claims so that they sound plausible – in this case they are justifications for current practice or beliefs. Such justifications can be similar and inconsistent between and within participants and may justify prejudice in non-prejudicial terms. Gill (1993) suggests that people have a range of explanations and justifications they can draw upon to justify behaviour and beliefs. Therefore, it is important that I did not merely examine the repertoires as a statement of fact but analysed each in terms of its discursive function(s) - examining how they may blame others for the way things are and how they evade self-blame.

I explored the ideological effects of the discourse/arguments they used and how they propagate inequality, power and control. Each of these practical ideologies was then analysed in the following categories, searching for the ideological effects of discourse:

- The social relationships suggested in the terms used.
- The ideologies underpinning the terms they suggest.

⁷⁸ This method of analysis was developed from Marshall and Raabe (1993).

⁷⁹ For a list of original paradoxes found in the data please see Appendix 13 (please note that these paradoxes have been refined into only six paradoxes used in the results).

- The actions that these discourses legitimate

[Developed from McNaughton, 1993].

It was important that I avoid reductionism - the analysis is not about finding the villains who are deliberately creating and maintaining discourses – but this does not mean that there is no agency either. I was aware that the micro-discourses have reductionist ideas of individual agency and blame and the macro-discourses have reductionist views of discursive structures being deliberately created by a powerful few - and that such views are illusory (Parker and Burman, 1993).

The following are the final tree nodes used in the analysis. Each has child nodes attached to it (some up to sixteen child nodes). A full list of the final fifty-six nodes used in the analysis may be found in Appendix 11 with descriptions available.

Node list:

- Descriptions of men
- Authoritative corroboration
- Relationships
- Humour
- Power issues
- Judging on disability
- Experiences of the MSU
- Empowerment issues
- Learning disability
- Men's view of staff
- Research
- Professional discourse
- Influences on staff
- Staff issues

Vital sources of data included: quotations; observations; researcher notes; a pertinent vignette; insights recorded during or shortly after workshops; and diary entries. However, all data cannot be

included in the results, so any data which principally caught the essence of the idea, or that represented general viewpoints or ideas, or provided a particularly good example, were used in the results section (Wolcott, 1990; 45-64). The interviews and workshops in particular produced data that was relevant to the LS but not to this analysis and were excluded from these results, but reflecting the complexities and the interesting 'messiness' of qualitative research (Coffey *et al*, 1996). There were other nodes in which the data were repeated in related nodes, or rejected as unsuitable for the study (Flick, 2006; 295-319). These results have been written up honestly, demonstrating how the data has been interpreted (Potter and Wetherell, 1987; 169-189; Talk and Text, 2006).

The advantage of using such a system as NVivo is that any number of links in data and interpretations may be created by the researcher - but the usefulness of this infinite analysis may be questionable. All research has limitations, in that the research questions require answers within a specific timeframe and a specific word limit (Coffey *et al*, 1996). The available texts were investigated and the codes refined until the data produced no further insights, and it became clear that no new data were being added to the nodes; all of the data were trawled at least twice. This theoretical saturation occurs when further coding of data fails to enhance codes or add knowledge to the analysis (Flick, 2006; 342-356).

Summary

This chapter described the theoretical and conceptual framework I have used in this study. It described the methodological approach and its links to the conceptual framework and methods employed. It explains the methods of data collection and analysis in an honest and transparent way. These methods analyse key texts, policies, the social world and current models of disability for macro- and micro-discourses; exploring what having a learning disability means. In this case, macro discourses mean the meta-theories which are accepted by society - for example, social role valorisation (SRV), which also exists in policy and may be accepted into everyday discursive utterances. Power, therefore, may be linked with power imposed from above as something that is constructed by us all - by some common assent it exists all around us as we accept the macro-discourses as truth and go on to reinforce them. The micro-discourses are those which are spoken in

everyday language between the staff and the men and where bottom-up power exists - macro-discourses can also be used in everyday language. This thesis has examined micro- and macro-discourses and 'captured' discursive power wherever it exists in the data through using CDA.

It may give some people with a learning disability a voice and, therefore some power, since this research may influence nurses' practice, and their own and others' care. The study deliberately highlights positive aspects of having a learning disability, which are contrary to commonly-held negative assumptions: and explores the ideologies underpinning nursing practice and the tensions that are created. The next three chapters discuss the findings of the analysis through four themes: representations of the men; positive representations of the men; security; and experiences of the MSU and of forensic practice.

Chapter 6 – Representations of Learning Disabilities

The following chapters set out some of the findings of the analysis, its interpretations and discussions. They are not meant to show individual responses of participants but their shared repertoires, as the repertoires espoused were found to be drawn from by many of the participants. These were contradictory at times. It is not my intention to show contradictions in individual participants, but to demonstrate the contradictions in the way that people with a learning disability and forensic practice are viewed. It is appropriate that the findings, interpretations and discussion were placed together into three separate chapters relating to important themes found in the data. These themes are: representations of the men, including positive representations; security and discipline; and forensic practice: the security-therapy paradox.

The first theme (Chapter 6) relates to the many ways that the men are represented in the data as the same and different from others and challenge the negative ideas of difference by illustrating positive discourses. It interweaves the pertinent literature through the results and interpretations of the data. The second theme (Chapter 7) discusses security and discipline and relates to issues of detainment and security including choice, privacy and consent, the expectations of the men as patients and also examines the paradoxes which exist in the MSU in relation to relevant literature. The final results and discussion theme (Chapter 8), Forensic Practice, examines how the staff are viewed, the complexities of forensic practice and the therapeutic relationship through scrutinising the repertoires in the data and the related literature.

The present chapter is designed to illustrate the accounts of how people with a learning disability are viewed as different from the rest of society and how this justifies their treatment and detainment. The examples were chosen as the most appropriate and those which are considered the most important for the overall analysis. The practical ideologies related to particular repertoires and paradoxes are implicit within the arguments and the justifications for practices illustrated. The use and functions for each argument are then explored to illustrate the broad stories which are constructed and which expose their ideological base. The analysis demands that the justifications are not merely looked at

as a statement of fact but analysed in terms of their discursive functions, and therefore this part of the results will look at how they may blame others for the way things are and how self-blame may be avoided or invisible.

Further discussion of the findings and their relation to the literature and forensic practice continues throughout the chapter. The six main paradoxes are used as headings throughout the results chapters to arrange the data into manageable chunks:

1. The men are the same – the men are different
2. Learning disability is positive – learning disability is negative
3. Detainment is positive – detainment is negative
4. Low expectations of the men – high expectations of the men's behaviour
5. The men are entitled to the same rights as everyone else– the men's rights are restricted
6. Staff are caring and therapeutic – staff maintain security and are part of the system that detains the men

Each paradox is then illustrated by repertoires arranged into particular arguments (in bold italics) which support parts of the paradox. This chapter is concerned with the first and second paradox that I will consider; that of the men being viewed as different and as the same, and of opposing repertoires of learning disability.

Main Repertoires and Arguments Concerning the Representation of Learning Disability as Different and the Same

In this section I will demonstrate how ideologies regarding people with a learning disability as being different and devalued lead to them being more easily detained in the MSU. These ideologies are present in the discourse used in the macro-models of disability, national and local policy, and in the micro-level of the oral text of the men and the staff of the MSU. The medical and personal tragedy models declare that the differences proposed to occur within disabled people are entirely within the individual. This difference means that they may be separated from others and pity and control are dominant features of both models. The medical model goes further and classifies people because of their difference, usually by the type and severity of that difference. Those who are different may then be treated by specialist personnel to reduce the difference, usually for their own and/or the common good (Foucault, 1961, pp 195; 1975, pp 184-94). Therefore to be different is to be pitied, controlled and to be worked upon to become less different. In the case of people with a learning disability this was historically carried out through institutionalisation and later through training and education, where those who could not be trained were hidden away from society in large hospitals for treatment by the medical profession. Other macro-models such as the medical and personal tragedy models and social role valorisation (SRV) acknowledge difference as negative; such ideas are found in the data and used to justify differential treatment.

Nurses are also subject to macro-models and to their duty. Under the SRV model, this duty is to 'normalise' people with a learning disability in the eyes of society; to sanction them as equal and of the same value - repertoires which normalise the men can be seen as being used throughout the texts. Paradoxically, other macro-models, such as the social and affirmation models, define difference as positive and can also be seen in the data. If people with a learning disability are viewed as the same as others or difference viewed as positive, then it is more difficult for them to be treated in a different or devalued way.

The next section will consider how the men are represented and includes discourses used by the men and the staff, legislation, policy and, when appropriate, the macro-models of disability.

Paradox 1 – The men are the same - the men are different**Paradox #1 – The men are the same – the men are different**

People with a learning disability are the same so should be treated the same – yet they are different from others so may be treated differently

- The men are the same as others - but different from others
- The men are the same as each other - but different from others
- The men are the same as other people with a learning disability – yet different from other people with a learning disability

Repertoires of Sameness

The first arguments relate to how people with a learning disability may be defined as the same as everyone else. There are repertoires which the rest of society shares; repertoires of abilities, jobs, talents and rights - the men should also share such attributes if they are the same⁸⁰. Such repertoires are supported by several arguments – the men are the same as everybody else because of the following repertoires;

- 1. Everyone has a learning disability**
- 2. The men are entitled to the same rights and choices as everyone else**
- 3. The men have the same hopes and wishes as everyone else**
- 4. The men have abilities and can make contributions**
- 5. Given opportunities the men can be the same**

⁸⁰ For a complete list of repertoires found in the data please see Appendix 12.

*Repertoire #1 - Everyone has a learning disability****Everyone has a learning disability of some kind***

"...I mean any number of us could have a learning disability. I'm not too hot on maths; I could class that as a disability..." (Staff 4)

The staff member is describing a learning difficulty as a learning disability which serves to minimise a global intellectual deficit, to a single specific deficit. It serves to lessen the impact of the stigma attached to the impairment by normalising it, denying the existence of a learning disability and, therefore, denying prejudice.

People with a learning disability are just like everyone else

[When asked to describe himself]

"Just an ordinary guy I think... Everybody's got a learning disability, though, haven't they? In some way... I think everyone needs help in their lives. I think." (Joseph)

Here, Joseph describes himself as an ordinary guy, denying the learning disability, offending behaviour or that he is out of the ordinary for being detained in the MSU.

These arguments make the differential treatment of the men appear unjust, as it is based upon differences being apparent. It is a repertoire shared by the staff and the men and may be related to political correctness and rhetoric.

Repertoire #2 - The men are entitled to the same rights and choices as everyone else

The law, policy and the macro-models advocate for the rights of people with a learning disability and the importance of choice but, as can be seen from the data later (see Chapter 7 - Security and Discipline), the men do not always have the same rights and choices as the rest of society. The function of such repertoires representing the men's equal rights include normalising the men and ensuring that the listener understands that they are adults with equal status to every one else.

The men stated very clearly that they should have the same rights, and choices as every one else:

People with a learning disability should not be separated from society

Interviewer

"And that's not good, keeping everybody together? With a learning disability?"

Matthew

"No, it's not. No. They should be able to have the right to mix with people who are normal because it's wrong to single a learning disability person out." (Matthew)

People with a learning disability have the right to have the same choices as everyone else

"Everybody should get a choice, no matter what...Because it's a human right." (Luke)

Policy similarly claims that people with a learning disability are the same as everyone else, with the same contributions, rights and needs:

'Our new agenda needs to be based on social inclusion, civil rights, choice and independence. People with learning disabilities have the right to be full members of the society in which they live, to choose where they live and what they do, and to be as independent as they wish to be.' (Valuing People, DoH, 2001, 1.1)

As the policy has to state changes to their agenda so that people with a learning disability have the same rights, this suggests an acknowledgment that this is not currently the case. The ideologies suggested by the terms used are that people with a learning disability have the same rights as everyone else and should not be treated any differently.

Repertoire #3 - The men have the same hopes and wishes as everyone else

The hopes of the men may be similar to those of many people; to live independently, to have a nice home, get a job and spend the rest of their lives with a partner who loves them. Such repertoires serve to reduce the differences between the men and others, sending the message that they are 'just like us' and not 'other'.

The men share common hopes with the rest of society

[When discussing future hopes]

'Well to get out of here and start a steady life on my own. Or with a partner or something. Have a decent job. Go and visit my Mam's grave every now and again. And that would be about it.' (Joseph)

Despite living different lives from most people the men share the same hopes and dreams as most people have. Again, these arguments serve to show the men as the same, therefore not different or threatening or dangerous as they may appear to the public.

Repertoire #4 - The men have abilities and can make contributions

This argument demonstrates how the men are the same through repertoires which represent the men as making a contribution to society, as being valuable through having talents and abilities, insights, holding down jobs and helping others. The function of these repertoires is to show that the men have valuable assets to valorise them in the eyes of the listener and show that they can contribute, live rewarding lives and are valuable to society.

The men have had a job

"Aye. I used to be a DJ before I came in here." (Matthew)

Speaking at a conference

"Like in going away to the conference, how excited they [the men] were to speak in front of people. And when they came back [and said] "I've been talking to these people, these people." And it was lovely, really... And you think, "Eee, good for you", because I couldn't have done it." (Staff 6)

Here the staff are describing their surprise and pride in the men's ability to speak at a conference.

The men also acknowledged how their work and insights used in the LS have helped others outside the project. It was not just about local relationships, but their work has had an impact nationally and across the world.

The men's work has impacted world-wide

"[the results of the LS] has helped people at [local] university to understand has [how] we learn about research and this has been talked about at a conference in America the Department of Health has been to hear about our research." (Matthew – Diary)

These repertoires function to raise the importance of the men's work to international status.

The men could also show good insight into their position and how they believe they came to be on the MSU:

The men are insightful and talented

"...because I'm pretty good at pointing out facial expressions on people, like, who are low moods. Or if you could sense something, you know? Somebody going to go up a height [becoming distressed]. Or whatever." (Matthew)

"...I do art and stuff... [I'm] Easy going. I've got a good personality, a good understanding... I'm known for... my art and everybody likes my art better..." (Mark)

Here the men are expressing the things that they do best, illustrating to the listener that they have valuable attributes and can contribute.

The men have self awareness

"And I do tend to get frustrated when things really don't add up, you know? Like, if, say for example, like, I wanted to go out somewhere... And then somebody would say, "No, you can't get that." Then I would try and sabotage it... But that's just me, I think. Like that's just a cry out for help basically, type. The way I tend to act like that. But if things go my way I'm generally happy and I'm very cooperative." (Matthew)

In this case, Matthew is showing great self awareness, a skill which is highly prized in nursing, psychology and psychiatry – three of the disciplines which heavily influence the men's treatment.

The men are helpful to other men

"Some [men] struggled, some seemed to grasp it quicker than others. And I think there was times where the ones who grasped it quicker were trying to help the ones who weren't... That's probably the best way of getting it across – peer helping peer, as opposed to staff all the time, sort of helping. Which was nice." (Staff 7)

There is hesitancy in the second sentence, where the staff member avoids using terms that may appear negative or offensive when talking about the men who did not understand immediately by not finishing the sentence:

"Luke's understanding of the material was seemingly greater than that of John's but he was able to... kind of coach, if you like, and assist him to develop his own answers." (Staff 4)

The men offered each other support and help and gained in confidence as they progressed through the LS; back on the flats that they shared, they would help each other to understand the very difficult concepts involved in research. But it wasn't just the men being helped, they also helped others including the staff:

It is not always the men who are helped, they help others too

"In a way, because they [the men] attended more sessions [workshops for the LS] and their knowledge was greater of the work that they'd been doing than my own – [there was] a bit of role reversal as well... [as the men began to explain to the staff what was going on in the study]..." (Staff 4)

"It was also important that support was something we all gave. It wasn't just supporters helping out researchers with learning difficulties we all helped each other. It was a two-way thing." (Mark – Diary)

The men were also reported to have a good sense of humour and enjoyed ribbing the staff as well as each other:

The men have a good sense of humour

"Well, yes, because he's a good character [talking about one of the men]. And he is a good laugh. He's got a good sense of humour. I think that makes up [for a lot]. I don't think you can have everybody who was widely knowledgeable. That knows everything..." (Staff 6)

"I mean, [staff name] made a pictorial chart for the patients on our ward. I mean, there's different ranges [in ability] depending on what unit you work on, [so] to try and let them remember what job they're on each day... [the staff put up a timetable of jobs]... there's a picture of a washing machine, picture of dishes. And, I mean, [staff name] did a picture of a Hoover [vacuum cleaner] and one of the patients thought he was on beehive duties. Because it was that shaped [like a] Hoover. So, I mean, you're really talking "What job are you on today?" [and the men replied with humour] "Beehive." (Staff session)

Humour is viewed as an important asset in such settings and is used in developing and maintaining relationships. To view the men as humorous normalises them and emphasises an asset which is commonly prized.

Valuing People also acknowledges that people with a learning disability can live rewarding and valuable lives:

'People with learning disabilities can lead full and rewarding lives as many already do.'
(Valuing People, DoH, 2001, Foreword)

The fact that it has to be stated in policy suggests that it is a view that is not commonly held. There is also the use of the word “can” which suggests that only under certain circumstances this may be achieved.

The ideology which these repertoires and arguments suggest are; a belief in the men as valuable beings who contribute to society through their attributes and abilities. These are arguments shared by the participants, policy documents and the macro-models except those of personal tragedy and the medical model of disability. Positive identities may be important for disabled people in their own affirmation⁸¹.

Repertoire #5 - Given opportunities the men can be the same

The following repertoires serve to show that the status of the men is not to do with their personal abilities, but more to do with the opportunities that they may be given or denied. The participants describe how the men were excited by the opportunity to take part in research; something rare for men in their position.

The men were excited to be given a rare opportunity

“Because I’ve never done something where they call you out before [being chosen] – research and what have you. And it was just a good experience to get in on it. And take part in a group session. Where we were all talking about stuff and what have you.”
(John)

The staff explain that the opportunity to do something worthwhile, with a valuable end product, was a chance for the men to prove themselves;

Given the chance the men can prove themselves and excel

“They seem to get enthusiastic about it because they’re doing proper work.” (Staff 3)

⁸¹ Because the shared understanding that their experience is tragic is the way that society has disabled them, not that they themselves are a tragedy. Being part of a group is beneficial to those with impairments and a group which, without the impairment, one could not become part of. Furthermore, through the group expressing frustration and anger and dealing with it in a politicised manner, this means individuals should not receive treatment for their own frustration and anger; it is seen as a political problem, not a personal one – unlike the experiences of the men in this study. Finally, this positive group identity is important as it has enabled the disabled to create positive images of and for themselves and demand the right to be equal and different (Swain and French, 2000; 578).

"I just think it's very, very important. I think it's really giving them a chance to show they can actually do something. That they can actually have [design] a booklet, especially on a unit like this, when they're in a secure environment." (Staff 6)

The men become experts

"Oh, I think they [the men] really excelled. I think, really, they understood, probably more than what I, maybe, understand. You know, I think they got a lot out of it." (Staff 6)

One of the men also showed great insight into his new position as researcher, where he was now seen as the expert and not the subject of research.

"We all worked together as equals... This is important because for many years researchers was done by people who had lots of power to say what life experiences they were researching about... And their researchers were called "experts" and they made their careers by researching people who were called "subjects". (Mark – Diary)

Mark is describing how others called researchers used to be called the experts, but now he has been given the opportunity to become a researcher he can define his own life experiences and become the expert. The functions of such repertoires may be to illustrate that it is not the impairment, but the lack of opportunity which leads to the men not achieving; i.e. their disablement that affects their ability to contribute.

Repertoires of sameness, therefore, include beliefs in the men being the same as everyone else and serve to minimise a learning disability or any difference and legitimate their equal treatment. They are repertoires which are present in the social and affirmation models. The repertoires of sameness are present in policy and micro-discourses but do not appear dominant as they may be qualified with a 'but', which often leads to discourses of difference and does nothing to enhance ideas of positive difference.

The next section explores the repertoires which represent the men as different and not the same.

Discourses of Difference

Different and Disliked

The message is that to be treated the same as everyone else is a desirable thing and is present in the micro-discourses used by the participants:

"Because, like, in a way some people might think that he's not normal. He's got something loose. Do you know what I mean?" (Mark)

Mark's idea of normal is to not be seen as having "something loose" (presumably a screw). To view the men as different has connotations of devaluation attached to it and enables and justifies the diverse treatment of those defined as different.

The view that sameness is valuable is present in national and local policy:

"Children with learning disabilities want to be treated like other children, not always seen as "special", and to be included in ordinary activities." (Valuing People, DoH, 2001, Preface (clear messages))

However, this is not a discourse of meaning for those in our society seeking wealth and/or fame; doing ordinary things and being average is not desirable to everyone. It is not merely about being different; most people would like to be extraordinarily wealthy, beautiful, intelligent, articulate and fit. It is about something altogether more significant. It is about the value of what is different about people – not only different, but disliked. Defining the men as different is important as this difference may be viewed as negative - this is crucial for the establishment of a 'normal' in-group which they are excluded from. Therefore, they are negatively different and of less importance than others and so can be treated differently to others.

There are definitions of learning disability in the literature. Commonly the Mental Health Act (MHA) (1983) definition is used, as it is in Valuing People (DoH, 2001). A lot of the participants had problems defining and describing the term learning disability:

*[when asked to define learning disability]
"I don't know. I'm confused." (Joseph)*

There were long pauses in the transcriptions and some (perhaps nervous) laughing as the participants described something that they live with and work with on a daily basis. Some participants used the medical and legal definitions; their difficulty is apparent:

"(laughing) Good grief. Oh dear. I don't really know. I could go into the genetics of different degrees of learning disability, not necessarily from birth but it could be from a variety of reasons; Down's syndrome etc. If it you were explaining it to someone from outer space, what is autism, what is Down's syndrome, you would have to go into, sort of, the genetics of everything... I don't know, I'd probably have to sit down and think and I'd probably have to write notes and everything because it's quite a... it's so... it's quite an expanse subject, what is a learning disability." (Staff 4)

Such trouble was common throughout the data and may have arisen because there are so many facets to learning disability⁸². The difficulty could also lie in the usually negative definitions which employ deficits, negative effects of the stigma or medical categories to describe learning disability. This is because people may wish to distance themselves from negative labelling as demanded by the 'politically correct' ethos or present rhetoric.

The following are the repertoires which are used to illustrate how the men are different from others in society:

1. **People with a learning disability are disadvantaged**
2. **Discourses of deficit**
3. **The men have a diagnosis which separates them - they are ill**
4. **The men are different from other people with a learning disability**

Repertoire #1 - People with a learning disability are disadvantaged

There is nothing good about having a learning disability

[when asked if there is anything good about having a learning disability]
"No... Nothing. Only the support when you're outside." (Matthew)

⁸² The group is not a homogeneous one and share only their experiences of disablement as their learning impairments range in severity and effect

Learning disabilities have traditionally been linked with disadvantage, poverty and low social status.

Note this is because of social issues, and not the impairment itself.

Learning disability is linked to poverty

'Mild to moderate learning disability, however, has a link to poverty and rates are higher in deprived and urban areas.' (Valuing People, DoH, 2001, Chapter 1, 1.9.)

People with a learning disability are discriminated against socially and in education, health and employment

'The NHS Plan made clear that inequalities in health cannot be tackled without dealing with the fundamental causes including poverty, low educational attainment, unemployment, discrimination and social exclusion. These factors affect many people with learning disabilities, and their high morbidity and mortality rates show the importance of addressing their needs.' (Valuing People, DoH, 2001, Chapter 6, 6.24)

The functions of the repertoires of the social model of health in the policy above serve to illustrate how it is the social issues and not the impairment which create difference. One of the issues reported to separate the men from others in society is their dysfunctional backgrounds; which are not only poverty-stricken but may include familial psychiatric issues and criminality. The staff report that structure to their day is important and may have been historically missing:

The men come from disadvantaged and dysfunctional backgrounds

"Well, you have to have structure and most of them aren't used to structure and occupying them too, giving them something to do because boredom is something that is you know, very easy... their mood changes very easily when they have got nothing to do... 'cos if you just left them to their own devices they wouldn't be getting out of bed, you know, the whole day would be totally upside down kind of thing and if they haven't had structure before you know a certain structure is very good for them." (Staff 5)

Such arguments carry beliefs in fundamental differences in the men, justifying differential and restrictive treatment because of that disparity; in terms which appear understanding and non-prejudicial (see later in Experiences of MSU Chapter). They have underlying ideologies that society is to blame for the men's position and may excuse the men for their behaviour, as it is their disadvantaged and dysfunctional backgrounds which have led to their offending behaviour.

Repertoire #2 – Discourses of Deficit

This is a very important and common discourse regarding people with a learning disability and such deficit discourses are present in macro-models, policy and in the micro-discourses of the participants in this study. The following extract illustrates how the men believe that having a learning disability is viewed by others. Luke describes the way that they are perceived as someone who can't do many things:

People with a learning disability 'can't do'

[when asked to describe himself]

"Learning disability makes me think that I can't stand up for myself. I can't look after myself. Which I know I can. In areas that it looks pretty bold to me, thinking, like, learning disability meaning somebody that can't read, can't write, can't spell, can't mainly communicate in the right way. Can't go out and get a normal job. Can't go out in live independently. You know, like it means got no independence." (Luke)

[when asked if he had a learning disability]

"Well, in the majority I can look after myself and I can, like, read and I can write. I can do a lot of things. I know right from wrong. I know when I'm doing something wrong. But I just tend to carry on and do it, you know?... [it makes me feel] Awful." (Matthew)

He describes not having independence, which has high status in our society and is a dominant facet of SRV. People who are independent and "can do" are productive and to be admired – those who are not independent and "can't do" are reliant upon others to help them and are not valued. It can be argued that celebrities and the royal family are not independent as they rely on so many people to help them – so it may be something about the type of independence that is different and judged as negative.

The participants and policy commonly describe learning disabilities in terms of needs or deficits.

The men are described by deficits

"We have a problem that a lot of our patients just repeat what they've heard... They haven't got an opinion of their [own]... They tend just to repeat... some people do have their own opinion but not [all]..." (Staff Session)

"Learning disability is first used when somebody doesn't understand stuff quickly and find it hard to cotton on to things." (Luke)

Below, Luke is using categories and medical and psychological terminology to describe his impairment, but he describes the categories as fluid and not absolute as he is striving to improve:

The men do not have a normal IQ

"Yeah, a mild one... Because my IQ is 95 percent and my understanding is just a little higher. But the fact is that when I was in school I went to a specialist school because I had it... And I know I've got it because all the tests prove I've got it [a learning disability], plus my reading and writing is not 100 percent. Unlike normal people who've got even a small disability or any other, I actually try and read and write. I'm learning at the minute to try and improve it." (Luke)

Luke may have picked up medical/psychological terminology throughout his time in the CJS – describing his IQ as 95 percent (- i.e. below 100 percent) and describing others who are 'normal'. Such repertoires hint at blaming disabled people for their disablement.

It was difficult for the participants to express any positive aspects of having a learning disability when asked. Please note that the negative aspects reported are usually to do with the way the men feel or are treated because of their impairment, not to do with the impairment itself.

It is the way the men are treated (because of stigma) and not the impairment which is negative and disabling

"No... Because, like, in a way some people might think that he's not normal. He's got something loose. Do you know what I mean? And you're thinking, "I haven't..." (Mark)

"...nobody will want to employ you. Basically. As in a proper job... you've got to go to these sorts of, like, day centres. You know, they tend to keep mainly all the learning disabilities together. Like, working in like separate places like ____ ...No, it's not [good]" (Matthew)

The negative aspects of being diagnosed with a learning disability and treated differently are understood and articulated by the men:

The stigma attached to being diagnosed with a learning disability is disabling

The deficit the men apparently have is less clear-cut. Here, Luke acknowledges the effects of the term itself on the individual. It is not the initial impairment, but the fear that it causes that affects people with a learning disability:

"They have their own ideas but they can't always express it because the learning difficulty discourages them from learning. Because a load of people are frightened of learning because they know they've got it and it scares them. They're frightened that if they do learn some information, they won't understand the information, and they won't know whether they can take it in. Plus people who have got it normally find out that they can't read and write properly and are frightened to try." (Luke)

"It makes me feel that I've got no control on looking after myself. It's just like your parents bringing you up when you're a child. It feels like that. But I'm saying, well, I'm no child. I say I'm old enough to make my own decisions and I don't need that sort of, like, thing, like banner over my head saying that I've got a learning disability." (Matthew)

In the main having a learning disability is viewed as a negative thing. Rarely in policy are there accounts of advantages:

People with a learning disability rarely have friends or jobs

"Social Isolation remains a problem for too many people with learning disabilities. A recent study found that only 30% had a friend who was not either learning disabled, or part of their family or paid to care for them... Employment is a major aspiration for people with learning disabilities, but less than 10% nationally are in work, so most people remain heavily dependent on social security benefits" (Valuing People, DoH, 2001 1.18)

Please note this abstract is again discussing the effects of disability not the impairment. The uses and function of describing the men in negative terms and in language of deficits define them as outside the norms of society. This difference is not good, as in others who excel in beauty or intellect, but is seen as an undesirable difference. The deficit repertoires are similar to those found in medical and personal tragedy models of disability and develop a rationale for extra help and resources to be given to the men.

Ideologies here are of difference being negative as it is associated with deficits: *ergo*, having a learning disability is negative. The deficit repertoires which were used by the participants are present in policy and the personal tragedy and medical models of disability. They describe people with a learning disability as outside the norm and unable contribute to society, so below others – this offers a rationale for extra help and differential treatment.

Repertoire #3 - The men have a diagnosis which separates them – they are ill

Such repertoires show that the men have deficits and additional problems. The latter are either illness or related diagnosis of disorders or challenging behaviour which justify treatment under the MHA (1983). When asked, some of the participants turned to medical and legal definitions⁸³. These are similar to those used in the paradigms of pity and control, such as personal tragedy and medical models. The medical model is also evident in the term 'patient' which is used throughout the text to

⁸³ Such as those from the MHA (1983) or Valuing people (DoH, 2001).

refer to the men. This term is also used by the men to refer to themselves. This medical ethos enables 'treatment' or interventions to be carried out on the men. This serves functions of creating medical specialists who can treat such illness/disorders and removing blame from the men as it is their illness that makes them offend.

The perceived level of impairment and deficits in ability are common forms of describing people with a learning disability, especially in policy:

People with a learning disability are described by their need and level of impairment

'...People with severe learning disabilities are those who need significant help with daily living... People with mild/moderate learning disabilities will usually be able to live independently with support.' (Valuing People, DoH, 2001, Chapter 1, 1.7-1.9)

People with a learning disability have reduced abilities and IQ

'Learning disability includes the presence of: A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;

- o *A reduced ability to cope independently (impaired social*
- o *functioning);*
- o *which started before adulthood, with a lasting effect on*
- o *development.*

This definition encompasses people with a broad range of disabilities. The presence of a low intelligence quotient, for example an IQ below 70, is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care.' (Valuing People, DoH, 2001, Chapter 1, 1.4)

The staff use medical and psychological terms like IQ to classify the men:

The staff classify the men in terms of ability

"I work on [unit name]. And that's with eight varying aged gentlemen with learning disabilities...To different degrees, to varying degrees... it's a long-term thing. If you've got a learning disability, you've got it for life..." (Staff 7)

Many of the men have a dual diagnosis of learning disability and mental ill health:

Commonly the men have additional mental health issues

'In addition to having a learning disability the individual would be expected to have either:

i) A mental illness.

And/Or

ii) Severe and enduring psychological dysfunction such that their everyday functioning is significantly affected.

And/Or

iii) Challenging behaviour of sufficient severity, frequency or intensity as to seriously jeopardise the safety of the individual or others, or as to seriously limit access to community facilities.' (Admission Policy, 3.2)

They are also described as a sub-set of those termed 'mental' in the MHA (1983) and in local policy:

Learning disability is viewed as a sub-set of people termed 'mental'

'The Sexual Offences Act (2003) in Sections 30 and 31 states that it is an offence for a person to cause, or incite another person to engage in sexual activity, if the latter has a mental disorder [as defined in the Mental Health Act, 1983] impeding choice. Many of the patients detained have precisely such difficulties...' (Sexual Relationships policy, 8)

Viewing learning disabilities as a sub-set of those termed 'mental' enables people diagnosed with a learning disability to be held under the MHA and subject to its conditions and detainment powers.

Note that these descriptions did not include the men; they did not describe themselves as ill.

If the men are seen as a sub-set of other devalued people, as in the case of the MHA (1983), it enables them to be not only viewed in a certain way, but treated in a irregular way; and one which is not particular to them, but to a whole set of other people who are viewed as different; people with mental health issues⁸⁴. This Act was put in place to protect people in psychological crisis which, in terms of people with a mental health problem, may be a relatively short period of time. There are people with chronic and enduring mental health problems, but their enforced treatment in times of crisis may be short-lived, especially when compared to learning disability, which is a life-long condition. Therefore, people with a learning disability held under the Act because of that impairment may be held for extensive periods, amounting to decades of time (Musker, 2001).

Even within the new MHA (2007), they are still the only group of people who can be held without having a mental illness (DoH, 2008a). Whether this was understood or envisaged at the time of the Act is not known, but the men, and hundreds of people like them, are being detained under this Act for considerable periods. If they could not be detained under the Act in virtue of their disability they would be placed in gaol along with other offenders and be released earlier than they probably would from treatment⁸⁵. So, by the fact that they are different - have a learning disability, and therefore can

⁸⁴ People with a learning disability can legally be detained under the MHA (1983) as they have historically been associated with people with the word 'mental' (Beacock, 2005). This has been anchored in legislation with the MHAs, 1959 and 1983 and continues today, where people with a learning disability are seen as a sub-set of those termed 'mental' in policy, and in the minds of society (Beacock, 2005).

⁸⁵ When in goal, a sentence is served; whether the offender has proven to be reformed or not. The law has prescribed a sentence and it has been served. However, because the men are held for treatment there should be outcomes, and one of the major concerns of the treatment is lowering risk; this is a clinical judgement, not a legal one, and may take years to realise.

be held under the MHA - they are detained in the MSU (for often longer periods) for treatment, rather than in gaol.

These repertoires rely upon beliefs that mental illness exists and that diagnosis may be accurate.

The functions of such medicalisation are to de-personalise - the diagnosis becomes the whole of how that person is defined, not as a person with Down's syndrome, but "A Down's syndrome" for example. It also acts as a barrier to blaming society for the lack of life chances that the men have suffered - as it is the illness which resides within the person that is the cause of the difference and disadvantage, not the way in which the person is treated by society. This is an important argument as it releases both society and the men from blame in the crimes committed.

Whilst *Valuing People* (DoH, 2001) calls for people with a learning disability to receive the same rights and life chances as others in society by using generic services, it even singles out those with complex needs, including people with challenging behaviour, to have specialist services. It begins by expressing their behaviour as being understandable, where psychotropic medication may be useful or where behavioural approaches can help reduce the behaviour. It also asks the reader to think about challenging behaviour in the way that *Valuing People* suggest - '*the way... people respond and try to gain control over difficult situations*', and end by suggesting specialist services are required (*Valuing People*, DoH, 2001, 8.44).

The men have been diagnosed with a learning disability and as having additional needs, which justifies their specialist treatment⁸⁶. Thus, they are considered to be in need of treatment and protection from themselves as they lack understanding, control and insight. It is because of their impairments that the men would find it difficult to serve their term in gaol. The medical discourses that serve to differentiate the men are not part of the men's repertoires. The men are not only viewed as lacking ability and understanding, but also as dangerous criminals; sex offenders, violent, and people who are difficult to manage. Therefore, the legislation and the code of conduct (NMC, 2002a) compel nurses to protect society from them, and act in their best interest - this is considered to be treatment in specialist units. It is not merely containment, since the medical connotations enable the residence in the MSU to be viewed as treatment; the detainment itself is a form of intervention.

⁸⁶ In fact, people with a learning disability commonly have additional and complex health issues compared with the general population so health treatment is more easily justified for this population.

The discourses of illness demonstrate beliefs in the importance of diagnosis, categorisation and assumptions that mental health issues are indeed an illness and that psychiatric diagnosis is accurate. This is something that is questioned in the literature as there are many complex issues with dual diagnosis; issues of the diagnostic overshadowing of learning disabilities and accurate diagnosis⁸⁷. For example, a normal part of their repertoires of behaviour - the phenomena of talking to oneself or fantasy play - may be misinterpreted as symptoms of psychiatric illness (DesNoyers-Hurley and Silka, 2003). Therefore, diagnosis for people with a learning disability may not be accurate (Spengler *et al*, 1990; White *et al*, 1995; Hardy and Bouras, 2002; Moss, 2003) and their challenging behaviours may be considered as a normal response to the abnormally disadvantaged lives the men have lived (Tew, 2002). Despite this, the repertoires of illness legitimate actions of differential treatment and justify detainment under the MHA (1983).

Repertoire #4 - The men are different from other people with a learning disability

The men are described as different, even from other people with a learning disability. In this example the participant is saying something about calibre – which could mean level or quality or could mean value.

The men are a different calibre compared to other people with a learning disability

"I was only here for one session and I did see a little bit of the film. A little bit of the DVD that you had. And the actor well, they weren't actors [in fact they were actors with a learning disability], the people doing the DVD ____ different, were of a totally different calibre to the type of patients we have here. With absolute different need to our patients." (Staff Focus Group)

The staff are making assumptions about the men and about the actors here, illustrating beliefs that people with a learning disability are not a homogeneous group and that the men are different because of their diagnosis and/or behaviour. Such arguments existed in the text from policy and the staff, but

⁸⁷ Accurate diagnosis of mental ill health may be problematic as there are, in fact, few psychiatric diagnostic tools available for people with a learning disability and any modifications to current tools may be problematic (Sturmey, 1995). People with a learning disability may suffer from the effects of diagnostic overshadowing where their learning disability is viewed as paramount in any diagnosis and one which appears stuck in the medical model, not the social model of health (Williams & Heslop, 2005; Michael, 2008; 15-16). Here, for example, a psychiatric symptom may be misunderstood as a part of their learning disability (as behavioural disturbances common in people with a learning disability) but may actually be due to psychiatric disorder (e.g. repetitive behaviour viewed as obsessive-compulsive disorder), (Fraser *et al*, 1986).

the men did not use these arguments - this may have functioned as a denial of the men's association with others with a learning disability or just that the men did not see themselves as different from the actors. Functions of such repertoires serve to justify differential treatment of the men from other out-groups, such as people with a learning disability; they are devalued even more than other devalued groups.

Difference is not always negative; disabled people have been fighting such assumptions for over thirty years. The next section highlights the positive aspects of difference in having a learning disability.

Valuing Difference: Positive aspects of learning disabilities

It is important to challenge negative notions of difference by accentuating positive aspects of learning disability (Goodley and Armstrong, 2001). The attributes of people with a learning disability have been described by self-advocates and others who do not themselves have a learning disability. Positive aspects for people associated with people with a learning disability reportedly include enjoying warmth, a pure kind of love, trust and acceptance and genuine concern for others – these are attributes which make it pleasurable to be around people with a learning disability⁸⁸. Self-advocates additionally reported particular attributes which make them valuable employees, who are good company, make work fun, raise morale and have a positive attitude⁸⁹. Similarly such attributes, relating to the men, were found in the data of this study.

⁸⁸ Please see: Brechin and Walmsley, 1989; 10, 161; Smith, 2000; 72;; Dune, 2001; 14; Race, 2003; 213-216;

⁸⁹ For attributes reported by self-advocates please see: Anya Souza, 2000; Dower, 2000; Docherty et al, 2005; 27-51; ; Personnel Today, 2007; Downs Syndrome association, 2007

Paradox 2 - Learning Disability is Positive - Learning Disability is Negative

Paradox # 2 – Having a Learning Disability is positive – Having a Learning disability is negative

- Having a learning disability can have advantages for people – yet there are many disadvantages to having a learning disability

Positive Discourses

Generally, having a learning disability may be viewed as a negative thing and the least desirable of the impairments (Deal, 2003). The following repertoires are concerned with representing the positive aspects of having a learning disability, which are:

1. **Having a learning disability was a great advantage when working on the LS**
2. **The men receive services and opportunities that are denied others**
3. **There is pride in impairment**
4. **It is good that people have a learning disability and are different, as this ensures different contributions are made**
5. **People with a learning disability do not have the same stresses as the rest of society**

Repertoire #1 – Learning disability was a great advantage when working on the LS

There are some positive themes linked with having a learning disability which may be found in the micro discourses and macro models, especially the affirmation model and Wolfensberger. For example Mark, John and Luke were very positive about the men's position in the LS, and could see how having a learning disability was a great advantage for them. This was similar to the views expressed in Docherty *et al* (2005); self-advocates who worked with researchers on an article and found that they had insider knowledge.

People with a learning disability are best placed to help other people with a learning disability to understand complex issues

John

"Because somebody who knows about it [research] and has got learning disabilities – [they] could explain it to somebody who has got learning disabilities. And then they could get better and they could learn more about it. And they'll go away and tell somebody [else] with learning difficulties about it."

Interviewer

"...Then lots of people with learning disabilities would know, Yeah, that's a good idea. I like that idea." (John)

If the men had not been involved in the LS it would have not been successful

"The fact that you want us to explain it to people with learning difficulties... It's no good putting a group of people into a room that have not got learning difficulties because you can't be certain that by the time that you came up with your booklet that you're going to give it to a person with learning disabilities... [they might say] "Oh, that's very good, that" but they'll probably not even understand it... This is how it is... Without us [the men] it would have been a waste of time doing it because by the time you've finished it you would have got to the point where you showed it to, like, 100 people with learning difficulties and they all went "Eh? [I don't understand]" (Luke)

"No. There wouldn't have been a success if we weren't involved... Because you wouldn't have had our input on the information. On the feedback and what we're saying about it... To get to know a bit more about the research side of it and what you needed and the pictures and what have you... So that you can get a better knowledge to find out by speaking to other people in a similar [position]... You know, with learning difficulties and what have you." (John)

The men had positive identities about their learning disability when working on the LS

"Mark has always been very positive about the benefits of working in a group. Today he said that although he appreciated my contribution he thought the way they all learnt best was when they discussed it amongst themselves. The reason he gave for this, that he said quite proudly, was that they had learning disabilities and I hadn't. I wasn't in the club!" (Researcher field notes/diary)

Such repertoires contain ideologies about insider knowledge, where people with a learning disability are the experts in their own impairments and about their being part of a group. Of course it also carries assumptions about other people with a learning disability being the same as them. The functions of such repertoires include having a positive in-group image - their learning impairment was an advantage to them in this study, not a disadvantage, which may have been their more common experience in academic work. This also helps to elevate their status, the men are the most important people here; they are the experts and they have the insider knowledge.

Repertoire #2 – The men receive services and opportunities that are denied others

There were some respondents who considered that having a learning disability was an advantage, as they would receive services and opportunities which they would have otherwise missed, as Luke and Staff 9 describe;

The men received extra help

“...when you learn and you just learn in your own time and take it bit by bit. If you don't understand and you've got people around you who do, don't be afraid to ask them to explain... The fact that I can write all my letters in my own way and I've got friends and people around me [in the MSU], and they'll sit and go through it with me and help me to correct it. They won't just leave me with it, they'll actually sit down with me... They don't rub it in, they just turn around and go, “Well, you've just got this letter and really it should be an “r” and not an “s”. And correct me and help me with it.” (Luke)

“...there's always going to be societies and professionals sort of assisting you on your way with everyday things.” (Staff 9)

The men do not appear to view their impairment as debilitating: it is the label and the stigma attached, and the way in which they are treated as a result, which are viewed as disabling. Their impairment is something that they develop strategies to overcome. The help that the men refer to is available to them precisely because they have a learning disability. Ideas of help suggest social relationships of power and charity.

The men are able to learn and move on at their own pace

“...in a way it's a good thing because, long term, it's going to give more people a chance to put themselves right properly, to move on in the future. Instead of rushing them through the system.” (Mark)

The men receive opportunities that others are denied

Luke

“And furthermore, when I found out that other countries were starting to get interested I went and rang my brother up just to give it a little rub in his face that I was getting sponsored by other countries.”

Interviewer

“That's not real though, is it?”

Luke

“Oh no, I told him that. I told him that because it was funny listening to him going, “No, no, no. You always do things...” I like having a laugh at my brother's expense.” (Luke)

Luke is talking here about teasing his brother, but his brother responds by stating that Luke always gets to do things, and presumably that he does not *because he has not got a learning disability*.

There are examples in the literature of people with disabilities escaping poor backgrounds because of

their disability⁹⁰. This is a good example of how having a learning disability may offer people services and opportunities that otherwise they would have been denied. The function of such repertoires is to offer an alternative to the tragic view of having a learning disability and to deny disadvantage.

Repertoire #3 – There is pride in impairment

Positive aspects of having a learning disability were not explicit in policy but appeared implicit in some of the phrases used to diminish the stigma:

People should be proud despite their impairment

'You should be proud of who you are' (Eve, Valuing People, DoH, 2001, Preface)

"And getting some ideas and putting them forward to the group. And then discussing it with the others... we had some brilliant ideas. There wouldn't have been a success if we weren't involved. Because you wouldn't have had our input on the information." (John)

This suggests that despite the impairment there are other things one may be proud of; people with a learning disability have attributes and characteristics other than their impairment and difficulties may be overcome.

It isn't the impairment that is negative, but the way that people deal with it

"If they've got one themselves [a learning disability] and they don't try and embrace it and do something about it, it makes me feel ashamed to say that I've got one because they're not even attempting to do anything about it. But then again, I also feel joy because I know, in myself, at least I'm trying and I'm willing to learn." (Luke)

In this example Luke is describing how he feels about having a learning disability. Firstly, he feels shame when people who have this impairment do not try to overcome it. Then he describes feeling joy at his own efforts at overcoming the impairment and his willingness to learn. It is not the impairment that he is ashamed of, but the unwillingness of others to try to learn. It carries ideologies of responsibility as well as pride. The function of this repertoire is to demonstrate how the impairment is not a negative thing, it is only negative if it is not dealt with positively and demonstrates pride in overcoming impairments. Interestingly this could also be used to justify prejudice by almost implying that if one doesn't learn then the fault lies within the person who is impaired for not trying, thus legitimising blame.

⁹⁰ See Swain and French, 2000.

Repertoire #4 – It is good that people have a learning disability and are different, as this ensures different contributions are made

Individuals bring their own unique talents and contributions

“...hearing it from what other people have to say on their points of views on it. Because there was different views from what everybody was saying. Not everybody was equally the same. So that was fun.” (Matthew)

“In their sessions [LS workshops] that they have, some excel in different areas and, you know they have different attributes that are individual to them and that they raise their self esteem through them.” (Staff 2)

If everyone was the same, we wouldn't get such a broad view

Interviewer

“Why was it important that you had to be there to choose the pictures and to come up with the words to explain things?”

John

“So that you can get a better knowledge to find out by speaking to other people in a similar... You know, with learning difficulties and what have you (John)

“Well, yes, because he's a good character. And he is a good laugh. He's got a good sense of humour. I think that makes up a lot. I don't think you can have everybody who was widely knowledgeable. That knows everything. You still need these [humorous] people in the course to balance things out, really.” (Staff 6)

Here the staff member is talking about one of the men with a particularly good sense of humour and the contribution that he gave to the LS because of that. This repertoire includes ideologies regarding the value of different contributions and the importance of fun and it legitimates the involvement of people with a learning disability in activities previously believed unsuitable. The function of such repertoires is to show that there are attributes other than intellect that are of value which enable a broader view as different people contribute different things. Despite the LS being of an academic nature, the humour element brought to it ensured that the research was enjoyable and interesting. Yet fun is something which is not generally reported as valued in research activity or by academics; it is not a dominant academic discourse, but one which was appreciated by the participants of the LS.

Repertoire #5 – People with a learning disability do not have the same stresses as the rest of society

Some staff believed that advantages in having a learning disability included less stress and a simpler world view:

The men are sheltered and don't have the same stresses as everyone else

"I think you're sheltered from a lot of home truths in a way, you lead quite a sheltered existence, there's always going to be societies and professionals sort of assisting you on your way with everyday things. You probably don't have the same stresses as a lot of people but you might have different stresses." (Staff 9)

It carries with it ideologies of less responsibility and stress for people with a learning disability; low expectations of them; and potential selfishness on their part. The function of such repertoires is to show positive elements of having a learning disability. But note the last phrase stating that the men "might have different stresses" than other people which may be an acknowledgement of the stress the men may have from being stigmatised, poor and/or from dysfunctional backgrounds, as well as being detained in the MSU.

The men do not have to worry about others and can concentrate on themselves

"Positive aspects of having a learning disability... let me think. Sometimes a simpler world view and in the particular client group I'm thinking of here, not necessarily worrying about others too much although they do have contact with their family. The clients here... I think it would be nice to just think about yourself sometimes, concentrate on yourself. (long pause)" (Staff 1)

This staff member had problems thinking of positive aspects of having a learning disability which can be seen from the "let me think" comment and the long pause. The positive aspect is stated as not having to worry about others and having time to concentrate on yourself. This is also present in the disability literature, where people with disability report not having responsibilities, as society has such low expectations of disabled people anyway - they are released from this responsibility. The function of this repertoire may be to show that disability has its advantages, but could also be used to express a view of people with a learning disability as irresponsible or selfish.

Such repertoires legitimate ignoring the disadvantages of disability; disregarding stress of disablement – for example, living in the MSU, disadvantaged background, vulnerability, offending and complex behaviour and dealing with mental health issues. The men did not express such repertoires.

There are many disadvantages to having a learning disability

In this paradox the men are seen as living less stressful lives than the rest of society and also as coming from terrible familial backgrounds of physical, psychological, sexual abuse and other physical and sensory disabilities.

- **The lives of people with a learning disability may be more stressful as they are more likely to come from poor and dysfunctional backgrounds**
- **Sameness is valued in society not different-ness**
- **People with a learning disability are more likely to be abused**

These repertoires can be seen throughout the results and discussion sections and will not be repeated here.

Describing the men as different and the same

The repertoires showed that people can be different and the same; it is only when a negative value is placed upon the difference that negative treatment follows: the rich and famous are treated differently than most of society, but this is viewed as positive. Therefore, difference in itself may not be an adequate justification for unequal differential treatment. The text provides many examples where participants describe the men as different and the same, often in the same discussion. *Valuing People* (DoH, 2001) similarly describes people with a learning disability in terms suggesting them as different and the same:

Different – “*People with learning disabilities are amongst the most socially excluded and vulnerable groups in Britain today. Very few have jobs, live in their own homes or have real choice over who cares for them. Many have few friends outside their families and those paid to care for them. Their voices are rarely heard in public. This needs to change... Our new agenda needs to be based on social inclusion, civil rights... choice and independence...*”

Same – “*People with learning disabilities have the right to be full members of the society in which they live, to choose where they live and what they do, and to be as independent as they wish to be.*”

(*Valuing People*, DoH, 2001, Chapter 1, 1.1-1.2)

In the following example, *Valuing People* begins with a statement about focussing on people's abilities and then goes on to list their deficits in ability; defining them as people first, then listing the differences between them and people without a learning disability.

Same – *“Valuing People is based on the premise that people with learning disabilities are people first. We focus throughout on what people can do, with support where necessary, rather than on what they cannot do.”*

Different – *“Learning disability includes the presence of:*

- *A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;*
- *A reduced ability to cope independently (impaired social functioning);*
- *which started before adulthood, with a lasting effect on development.”*

(*Valuing People*, DoH, 2001, Chapter 1, 1.4 – 1.6)

The use of the first sentence, about focussing on what people can do, fades in comparison to the list of deficits which follows, and this feels very suggestive of rhetoric. The participants in the present study described the people with a learning disability as similar to everyone else – but they also described the men as different, even from others with a learning disability, since caution must be exercised when befriending them:

[when asked to describe people with a learning disability]

Same – *“Crumbs. (pause) Oh God, erm. I would say basically that they are people the same as us.”*

Different – *“...but they need more needs catered for. They need more help to do things with... sometimes they need people to stick up for them and help them out.”*

Different – *“...Basically, befriending them in a way but not so close as befriending them, you know [for security reasons], just basically helping them”*

Same – *“...giving them a good quality of life really, to be treated as I would like to be treated.” (Staff 3)*

These repertoires rely upon rhetoric and political correctness; stating that they are the same neutralises difference – justifying discrimination and treatment on unequal terms.

This is highlighted as one of the most important paradoxes in the data, since viewing people as different allows for prejudice and enabling specialist services which may be required to help - yet describing people as the same appears to be the “correct” way of defining people and helps to neutralise the differences described and justify prejudice in non-prejudicial terms. This leaves the participants and the text appearing confused on this point, but acts as a qualification for viewing and

treating people as different. The function of such a paradoxical text could be to allow the speaker to show the differences s/he perceives, whilst avoiding blame through emphasising their sameness with rhetoric; thus demonstrating that incompatible ideologies exist in legitimating differential treatment, whilst avoiding blame.

Summary

Justifications for the men to be treated differently are common in the data. One of the major arguments against specialist treatment for people with a learning disability is that they are the same as everyone else, with the same wants and needs. The macro-models and national policy remind us that they have the same rights as everyone else; and these include the right to be punished like everyone else and not to be held under the MHA by virtue of their having a learning disability. The participants in the study agreed that the men were the same as everyone else and should be treated as such.

National and local policy state that people with a learning disability should be accessing local and general services if at all possible and not living in NHS accommodation for extensive periods of time (*Valuing People*, DoH, 2001). However, the men in this study may live in NHS secure accommodation for many years. The men are held here because they are different as they have a learning disability and additional needs, which means they can and should be given specialist treatment. They have deficits and diagnoses and are considered dangerous and vulnerable. They are different even from other people with a learning disability because of their offending behaviour, mental health issues and background. If this argument is accepted then they should be treated differently. This treatment, when compulsory, restrains the actions both of the staff and the men.

People with a learning disability are not sick, although in England we have nurses for people with a learning disability - this is not an illness, though people with a learning disability have greater health risks than the rest of the population. These are reported to be linked to their individual genetic syndromes/aetiology, and/or their physical/sensory disabilities related to it, and the social aspects of their health, such as lifestyle and barriers to accessing services in a timely manner (Michael, 2008;

16). Whatever the cause of the impairment, it is generally accepted that the social implications of having a learning impairment compound the initial impairment and disable them. However, people with a learning disability may not need to be detained in a hospital and cared for by nurses. If they are convicted of a crime they could be held in gaol, although this is not always deemed appropriate (Skelly, 2001).

The participants listed numerous positive aspects of having a learning disability, advantages for the men and for the staff in working with people with a learning disability (which may be viewed throughout the results chapters). The positive aspects of learning disability reported included: the men having a good sense of humour; being tolerant of others; helping others; having a potential to develop; and having good insight into their own abilities. In fact, having a learning disability was viewed as a great advantage as the men got the help and support they needed and services which allowed them to work at their own pace to ensure that their offending behaviour changed. The advantages of having a learning disability when working on the LS were also evident. The success of the project, the participants felt, was entirely down to the men and their learning impairment and they recognised their own expertise in having a learning disability. Further attributes are discussed throughout the results sections.

The participants reported that the men surpassed all expectations that the staff and researchers held at the beginning of the project. Unfortunately, the staff and the researchers had many years experience of working with people with a learning disability and still managed to underestimate them. Such repertoires hold ideologies of value in difference and the men as experts and legitimate positive actions such as group identity and pride in the in-group. Yet they also carry assumptions about people with a learning disability being the same as each other.

This chapter described the oppositional repertoires of difference as something which is negative and leads to differential treatment: and positive aspects of having a learning disability where difference is viewed as positive for many reasons⁹¹. By exposing the inconsistencies in beliefs and contradictions in arguments and the functions of the discourse, I have also exposed the “material of ideology” (Fairclough, 2001); the way that repertoires are used and linked to issues of power and identity.

⁹¹ Please see Figure 2 - Representations of the men

These inconsistencies are nothing new in the literature and are consistent with current theory, but are exposed in this particular setting giving fresh insights into the justifications for detainment of the men.

By deconstructing the given “truths” about people with a learning disability and the men, the inconsistencies in ideology have been exposed. The men are seen as different and the same, as sick and not sick, as negative and as positive, as dangerous criminals and as victims, as able and impaired. There is no single truth here; nursing and medical knowledge, previously taken for granted, has been exposed as not so solid and scientific, but much more fluid and not as able to substantiate certain ideologies such as the justifications for detainment in the MSU. This suggests that the justifications may not stack up and different mechanisms for the safe treatment of the men may need to be sought.

The next chapter will explore experiences of the MSU for the men and the staff

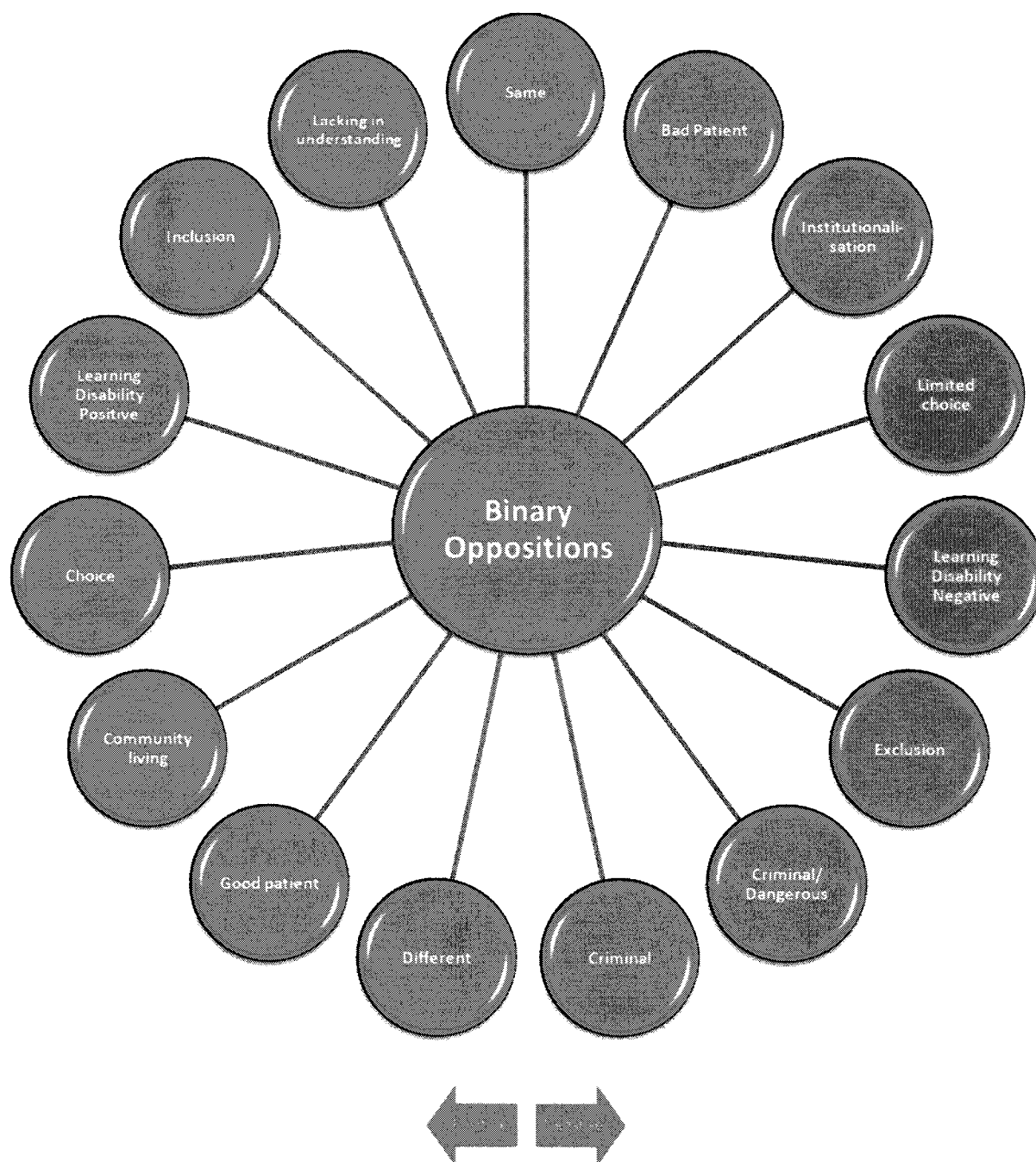


Figure 2: Representations of the Men

Chapter 7 – Security and Discipline

The previous chapter explored how the men are viewed as different and the same and explored positive repertoires, the functions of such repertoires and the practices which such repertoires justify. This chapter explores paradoxes regarding security and choice and is set out in the same way as the previous chapter. It illustrates paradoxes, repertoires and arguments using examples from the data and interprets functions, ideologies, assumptions and actions that such repertoires legitimate. The paradoxes are:

- Paradox # 3 - Detainment is positive – detainment is negative
- Paradox # 4 – Low expectations of the men – high expectations of the men's behaviour
- Paradox # 5 - The men are entitled to rights – the men's rights should be restricted

Security and Discipline

“In a sense, the power of normalization imposes homogeneity... making it possible to measure gaps, to determine levels, to fix specialities... It is easy to understand how the power of the norm functions... since within a homogeneity that is the rule, the norm introduces, as a useful imperative and as a result of measurement, all the shading of individual differences.” (Foucault, *Discipline and Punish*, 1975, 184)

In Chapter 2 there was an examination of power and discipline and I discussed that knowledge and power are inextricably linked. In any society the relations of power, which characterise the society, cannot be recognised without the construction and distribution of discourse; power requires the truths which discourse produces in order to refer to for authority - truths differ historically and are not necessarily universal (McHoul and Grace, 1993; 1-14). The sciences, Foucault believed, categorise us; the sick from the healthy, criminals from the good and the sane from the insane. This was differentiated through examination by experts; teachers, doctors and nurses who determine by examination who is outside of the norm. Individuals falling outside of these norms are shown to be given reduced privileges, lower status and even punishments; and so this process is deemed “essentially corrective” (*Discipline and Punish*, 1975; 179).

Singling out those outside the norms of the institution serves a two fold purpose; it encourages those being punished to try harder to reach normative behaviours; and discourages those already within the norms from falling outside of them for fear of the same punishment. Foucault believes that normalisation became an apparatus of power since it enables differentiation. Individuals become, not of themselves, but their identity is the product of discourse, ideology and social practices (Danaher, et al, 2006; 63-81). The next section is concerned with the way the men and staff experience the MSU as an uncommon environment; and security and its justifications for security are analysed in the texts. These include particular extracts from *Valuing People* (DoH, 2001); from local policy documents; and data from the LS.

Security

There are restrictions on the movements and activities of the men to maintain security. This is in place to protect the men and the public and, therefore, pervades everything in the MSU. Such restrictions are legitimised through policy and legislation - and reflect the beliefs, attitudes and values of our society (Beacock, 2005). There were long lists of things we could not do in the LS sessions and preparation we needed to carry out beforehand, as several staff pointed out:

"...I mean, certain patients we've got might go for you and grab your boobs. We've got one [a man] who can't help himself. ... I don't know whether you want to know about the patients that we're bringing before they come? Do you want a little bit of background information just for your own safety?"

"...You couldn't be left alone with some people."

"...If you've got cans of pop make sure you're not leaving the ring pulls and even a can around because they'll take the ring pull off. Do you know what I mean - cans are meant to be contraband."

"...And to non-MSU staff, and perhaps female staff, because of some of the issues around their [gender]... We need to ensure that everybody has been inducted as far as security is concerned. Devise and carry out security checks." (Staff Session)

The function of repertoires of security may be to enhance the status of security and justify restrictive practices. The whole of the security routine is justified because of the men's behaviour and risk.

Paradox 3 - Detainment is Positive – Detainment is Negative

Discourses of Detainment

Paradox 3 - Detainment is positive - detainment is negative

- The men are dangerous and require detention – the men are vulnerable and lack ability
- Detainment is positive because the men need specialist help and receive it in the MSU – yet the men are placed with people who are dangerous
- The men require specialist treatment – the men are bored and over-observed

Paradox 3 - Positive Aspects of Detainment

1. Discourses of dangerousness
2. Security is necessary for the good of society and for the men
3. To detain safely we need security
4. The men receive the specialist treatment they require
5. The men should be held in security because of what they have done
6. Given the right opportunity the men can achieve

Repertoire #1 -Discourses of Dangerousness

Despite risk of violence being difficult to measure accurately (Ross *et al*, 2008), ideas of dangerousness have been shown to be central to security and linked to learning disabilities, lack of understanding, mental health and complex behaviour (Robinson and Reed, 1996;152-163).

The men are dangerous

"But you've got to remember it's a secure unit so they've got to be supervised all the time. You've got to be careful because of what people are here for. Some people don't like women, some people don't like men so you've got to have to think about that." (Staff 2)

"...I mean, certain patients we've got might go for you and grab your boobs." (Staff Session)

"...because of security reasons for dangerousness to themselves, harming themselves or others, that can be limited and there are security issues on the unit." (Staff 1)

Some of the men are described as people who behave badly, but this is a rare example from the data.

Joseph is describing some of the men he has to share the MSU with:

The men are described as people who are violent and unkind

[when asked how he got on with others at the MSU]

"...Not too bad. I don't get on with one or two of them because they started name calling and that. Like I say, one of them throws cups at you and another one will say, "Go piss on your mam's grave" and all that. Which I feel like banging them sometimes. But, you just have to tell the staff and that." (Joseph)

The men don't understand their offences

Having little understanding of the offence is an important treatment issue (UKCC and UCLAN, 1999; 27-28).

"A learning disability is when somebody, like, does something wrong or does something and they don't know they've done that. And they don't know why they've done it or whatever." (Mark)

Many of the men have a dual diagnosis of a learning disability and mental ill health:

'Many of the men have a dual diagnosis of learning disability and a mental disorder or challenging behaviour which may make them a danger.' (Admission Policy, 3.2)

At times it appeared that the participants seemed to suggest that having a learning disability and criminal behaviour are both negative:

The men are viewed primarily as criminals

"After one of the sessions we were discussing the high level that the men were functioning at, as this level was beyond our expectations. One of the staff quipped "well of course they can think at that level, they are all planners aren't they" [with humour] – referring to the fact that they have had to plan their criminal activity, so the level of understanding was not so surprising." (Researcher Field Notes)

This was a clear reference to the staff member's seeing the men primarily as criminals and not as men with a learning disability.

These repertoires serve to represent the men as different, dangerous and complex and justify different treatment by specialists.

Having a learning disability is synonymous with dangerousness

According to Johnston (2005), lay opinion regarding offenders with a learning disability, falls into two camps:

- a) Those who believe that people with a learning disability are too vulnerable and unskilled to be capable of committing an offence.
- b) Those who believe that their disability predisposes them to commit offences.

Of course neither of these views is altogether correct. Some literature considers that people with a learning disability may be at more risk than others of being detained for certain offences. Whether this is related to their risk of offending or their risk of being arrested is not yet clear (Johnston, 2005).

Of course people with a learning disability and professionals are also subject to these discourses.

Therefore, it is unsurprising that such a paradox is present in the data:

[asked if he had a learning disability]

"Aye. Because I'm always in trouble with the law when I was outside. I kept getting locked up all the time. So I got this big one [long sentence] as well." (Joseph)

Here the men are suggesting that having a learning disability is synonymous with poor behaviour, and as they have a learning disability and are detained in the MSU these two issues may seem inseparable. Such repertoires may serve to justify their treatment in the MSU and release the men from blame for their offences.

Having a learning disability means people getting locked up

"[having a learning disability is] Well people get locked up and all that. There's people who, like, can't read and write and stuff like that. Can't look after themselves." (Joseph)

"It's a tricky question because I would say that there's only maybe a negative thing the fact that they are away from their [family]... not only because of having a learning disability but because of why they are here [their index offence]..." (Staff 5)

There is little separation between having a learning disability and offending behaviour in this example, and perhaps they are seen as the same thing. In fact, the men would not be in the MSU if it wasn't for having both.

It is the men's fault they are detained

"Aye, because it's your own fault for coming here... You're put on here for a reason. If it wasn't for that reason, you'd be on the other side." (Mark)

The view that the men are dangerous criminals confirms historical myths of having a learning disability being related to criminality. Discourses of dangerousness enable the men to be held in strict

security and managed differently, even from others with a learning disability and from their non-disabled criminal counterparts. They contain beliefs that the men are mentally ill and do not have the ability to understand their offences. Therefore the men may be treated under the MHA (1983) and detained for longer.

This justifies prejudice in non-prejudicial terms by blaming the men for their detention. It enables the way that society has treated the men to become unnoticed and avoid blame in their offending behaviour as the criminal activity lies within the men. Such repertoires illustrate beliefs in the criminality of people with a learning disability, their necessary detainment, and ignore the part that society played in their dysfunctional and disadvantaged lives. This can clearly be questioned as it is their learning disability which enables them to be detained in the MSU, not their offending behaviour. It is clear that if they had offended and were non-disabled, they would have probably been held for less time in gaol. The view that the men are dangerous criminals is at odds with the views of their severe deficits and needs, and that they are victims and vulnerable to abuse.

Repertoire #2 – Security is necessary for the good of society and for the men

Safety and security are taken very seriously by the staff in the MSU, as they are compelled by law, policy and the code of conduct.

The staff have a duty to protect

“Yeah. For instance, out of the six lads on here sexual offences has been part of their forensic background. If yourself, for instance, was taking part in a group setting there could quite easily be inappropriate sexual remarks, inappropriate touching at which point that would be my responsibility to intervene.” (Staff 1)

Such repertoires justify the constant supervision of the men because of their dangerousness. For example, staff justified being present at the interview by using specific examples of a man who doesn't like women (the interviewer was a woman) – warning “*you've got to be careful*”. This means that the staff will have to ask the men if they don't mind being escorted whilst giving the interview, but if they do mind then the interview cannot go ahead. Security is seen as of great importance in the MSU.

Security was important for the LS

Interviewer

"You said it was your job and you were observing ..Him for security reasons ..Do you think the research could have gone ahead without that?"

Staff

"Well, no, because there's always pens. You don't know... I know it's maybe just part of my job but there's always pens and I was always making sure where the pens were. You know? Just for my peace of mind, you know? Type of thing. That they're all there and just silly things like that, I suppose..." (Staff 6)

The importance of security is again being emphasised. The staff member is justifying his/her not joining in the LS sessions by having to observe the men and watch the pens – which could presumably be smuggled into the unit and used for mischief/weapons – in fact, they are classed as contraband. However, the speech ends with the staff member calling security issues *"silly things"*, contrary to former discourse.

The men's state of mental health means that they require security

'The MHA, Valuing People and Local policy advocate for the admission of people with a learning disability to hospital. The Admission Policy of the MSU states that a person with a learning disability and at least one of the following may be admitted.

- I) Mental Illness..*
- II) Severe and enduring psychological dysfunction...*
- III) Challenging behaviour...' (Admission Policy, 3.2)*

Such repertoires carry ideologies of the dangerousness of the men who can't be trusted and the staff as experts who may control and protect. There is authoritative corroboration in policy which justifies and legitimates the level of security, constant supervision of the men and the staff as experts.

The men need to be detained for their own good

The admission may go ahead if the person fulfils the criteria above and also if

'...the patient requires immediate hospitalisation to maintain his or her safety and/or the safety of others' (Admission Policy 8.7)

Admission to the unit can be viewed as a place of safety for people who fulfil the admission criteria. This is an important argument – with underpinning beliefs that it is for the men's own good and that staff are able to judge dangerousness, and also functions to enhance the importance of security. It is a bit like the 'better than prison' argument, and one which the MHA relies upon. Unfair and sometimes enforced treatment is justified by being in the best interest of the men. It is a common no-prejudice argument, deflecting blame from the people carrying out such practices on the men - where unjust and enforced treatment is justified as being in everybody's best interest.

Security is required for the safety of everybody:

"Again, if we're talking about people I'm in contact with here, erm... great, the more choice you can give the better. But again, of course, because of security or for reasons for dangerousness to themselves, harming themselves or others, that can be limited and there are security issues on the unit. We do our best that we can to get that balance right and depending on your particular viewpoint as to where you lean [towards security or choices]." (Staff 1)

The ideologies contained within such repertoires are those of dangerousness, and serve to put fear in others and justify restrictive practices via issues of public safety. It increases the status of the professionals as they are the experts who will ensure the protection of the public. It also illustrates the staff members' awareness of the security-therapy balance. It is questionable whether detention only for the protection of others is justifiable (Walker, 1991 cited Dale and Gardner, 2001; 251-271).

Repertoire #3 - To detain safely we need security

"If yourself, for instance, was taking part in a group setting there could quite easily be inappropriate sexual remarks, inappropriate touching at which point that would be my responsibility to intervene... Yeah. Things like that, there's not much you can do, that kind of supersedes... the problem from my point of view would be the safety of yourself and other clients supersedes the results of research. Erm... and empowering them and feeling research is important... to me that (security) is more important." (Staff 1)

Such arguments contain elements suggesting that security is *the* most important issue on the MSU. They justify restrictions on the men's movements, privacy and choices by the appearance of danger and need for security. Security in forensic settings is required by the Ministry of Justice to be equivalent to prison - where the men may have been diverted from - and must comply with guaranteeing the safety of the public, patients and staff whilst providing a good quality of life and care. These are the two key objectives of the Special Hospitals Services Authority, (Dale and Gardner, 2001; 255).

Repertoire #4 - The men receive the specialist treatment they require

The men are being given specialist help that they need as an alternative to prison, which may be more difficult for men with a learning disability to cope with and justifies the longer sentence they may receive in the MSU compared to gaol:

MSU better than prison

"... I think it [being detained on the MSU] was better than when I was being in prison and that." (Joseph)

MSU gives the men an opportunity to get better

"In a way it's uncomfortable [being seen as having a learning disability and being on the MSU], do you know what I mean? But in a way it's a good thing because, long term. It's going to give more people a chance to put themselves right properly, to move on in the future. Instead of rushing them through the system." (Mark)

"Because there's some things in my life I've made mistakes and I've put my hands up and said that I've done wrong but at the same time they've tried to push me through the system too quickly. And I wasn't comfortable with them pushing me through too quick. And I just wanted to take my time. And face it." (Mark)

Such repertoires contain ideologies of the men facing up to their offences and that detention is successful. They justify the men's detention in the MSU both as treatment and because the men could not cope in gaol. Assumptions that the men are ill are prevalent and so the staff are viewed as experts who can treat the men.

Repertoire #5 - The men should be held in security because of what they have done

The function of such repertoires may be to suggest that justice is being done, as they are being punished for what they have done:

It is the men's fault that they are detained

"Aye, because it's your fault for coming here. It's your own fault for coming on here, do you know what I mean? You're put on here for a reason. If it wasn't for that reason, you'd be on the other side. You wouldn't do wrong what you did to come up here. Know what I mean?" (Mark)

The view that the men are dangerous criminals confirms historical myths of learning disabilities being related to criminality. The uses and function of such repertoires enable the men to be treated differently, even to the standard treatment of non-criminal people with a learning disability or other criminals too. Therefore, the men may be treated under the MHA (1983) and held for longer periods than their counterparts. Similar repertoires embrace beliefs that it is no-one else's fault but the men's; they excuse society, the men's backgrounds⁹² and the law⁹³ for what has happened to the men. This legitimates no action being taken as it doesn't matter about the fairness of the detention as this is the men's own fault; preventing any discussions about the rights and wrongs of such detention. It is no-one else's responsibility⁹⁴.

⁹² Which are commonly poor and dysfunctional. Medical studies show that those in contact with services earlier are less likely to end up in MSUs.

⁹³ People with a learning disability are treated differently from the outset

⁹⁴ In this sense detention may be viewed as punishment.

These repertoires can clearly be questioned as it is the men's learning disabilities which enable them to be detained in the MSU and not merely their offending behaviour. The view that the men are dangerous criminals is at odds with the views of their having severe deficits and needs, and also the view that they are victims and vulnerable to abuse.

Repertoire #6 - Given the right opportunity the men can achieve

The MSU may be the ideal place for the men to be given the opportunities that they need to achieve to be released. The participants had some expectations as to how men with a learning disability would understand research, as it is a very complex and abstract concept. The fact that all participants expressed surprise at the men's level of ability shows how low their initial expectations were:

There is a low expectation of performance for the men

"Like, I knew because I've worked on [unit name] before [with] Luke... And really he's understood a lot more than what I thought he would, really.... You think that they have like a less of... An understating, really. But they haven't. To me, like... They've shown abilities that I didn't think they would be able to do. You know?" (Staff 6)

Low expectations for people with a learning disability are expressed throughout the ways in which they are described in terms of deficits. When given the opportunity though, the men surpassed their own and others' expectations:

The men surpassed everyone's expectations in the LS

"Thank you for letting me do research. It has improved my thinking and understanding and using words [words] like

1. *methard [method]*
2. *understanding*
3. *consent*
4. *Able to show that I also can do research and that to me is important*
[important]" (John - Diary)

"I've always thought people underestimate people's learning abilities. And I've always thought I was pretty good at not doing that. I thought, you know, that I had a good expectation of what you [the men] might be able to do. But you exceeded all my expectations. And it made me think that I had underestimated you as well." (Researcher – interview)

Despite the low expectations, the participants acknowledged the importance of giving the men the opportunity to participate:

Opportunity is the key to success

"It's really giving them a chance to show they can actually do something. That they can actually have a booklet – especially on a unit like this when they're in a secure environment... Like in going away to the conference, how excited they were to speak in front of people. And when they came back [and said] "I've been talking to these people, these people." And it was lovely, really... And you think, "Eee, good for you", because I couldn't have done it." (Staff 6)

'There is no "quick fix" solution to these problems [social isolation/exclusion etc]; tackling them requires radical change from all of us. We need to develop a new approach to delivering better life chances for people with learning disabilities.' (Valuing People, DoH, 2001, Chapter 1, 1.23)

The ideologies contained within these repertoires are a belief in success and high expectations for people with a learning disability when given the right opportunities. They show a belief in their ability; their lack of achieving is due to their disablement and not their impairment. They function to create positive ideas of learning disabilities where people may be able to achieve, and legitimate providing specialist opportunities and services for people with a learning disability.

Paradox 3 - Negative Aspects of Detainment

Detainment in the MSU is considered generally negative for several reasons:

- 1. The men are not being treated in the MSU**
- 2. The men are separated from their loved ones**
- 3. The men believe others in the MSU to be unkind and dangerous**
- 4. The men are passive victims**
- 5. People should not live in NHS long stay hospital premises/the MSU**

Repertoire #1 - The men are not being treated in the MSU***The men are not being treated, merely detained***

Despite claims of treatment during detention, some patients stated:

"...all I'm doing is just sitting in the day room, which is really boring." (Matthew)

Here, the staff are not viewed as experts after all. Discourses of treatment may serve the function of enabling the social problem (i.e. the men) to be detained seemingly for the purposes of treatment.

The discourse suggests that no treatment is taking place. Instead, the men are excused from not doing anything considered constructive and the process of detention is made legitimate, except for

punishment. It also may excuse their “bad” behaviour, as their boredom could be blamed for leading to such behaviour, as suggested in the data.

Repertoire #2 - The men are separated from their loved ones

The men are considered to be a special group whose needs may not be best served in generic services. Therefore, the medium secure services available to them are not common. This means that the men may be further away from family and friends than offenders without a learning disability.

This was acknowledged by the staff:

Staff recognise the men's feelings

“...they are away from their family so [detainment is] a negative kind of thing and nobody wants to be here when they first come. You know, they often say they shouldn't be here or they don't want to be here, they miss their families, they miss their life...” (Staff 5)

The ideologies in such arguments include the belief that detainment in the MSU may not be in the best interests of the men. The functions of such statements serve to show how the men are treated differently and disadvantaged because of the rarity of specialist services for men with a learning disability. Therefore, such repertoires question whether such detainment is justified, and in their best interest. They also demonstrate that the staff are sympathetic to the men's feelings and show insight into their emotions:

Repertoire #3 - The men believe others in the MSU to be unkind and dangerous

Some of the men report that they do not get along with the other men who they have to share their living quarters and work with. The men here are often described as having very complex needs.

The men don't always get along

*[when asked how he got on with others in the MSU]
“My entire life is crap.”* (Luke)

“...I don't get on with one or two of them because they started name calling and that. Like I say, one of them throws cups at you and another one will say, “Go piss on your mam's grave” and all that. Which I feel like banging them sometimes. But, you just have to tell the staff and that.” (Joseph)

“But I have got friends around the hospital. But not up here [in the MSU] I haven't.” (Matthew)

Here, the men are describing the people with whom they live as people they would not like as friends.

The men shared forced and confined intimacy with others who they would not normally choose to be

with, having little privacy from the other men or the staff because observation levels ensure that they are rarely alone.

Such statements include ideologies of detainment in the MSU as a poor and unhappy experience with the men having to be detained with other unpleasant men. Although the vast majority of statements were positive about the staff, one of the men even reported some of the staff acting unprofessionally:

The men don't always get along with staff

"Well some, the nurses, one or two of them do piss taking and that. Of other patients and that. About, I would say, about three or four staff will do it and that. Take the mickey [tease] and that." (Joseph)

Teasing could be described as humorous and humour has many functions; some of these are to do with power and cruelty, and others to do with bonding and friendship. With the power imbalance between the staff and the men, such teasing may be an unacceptable abuse of that power. Of course, it may also be misunderstood by the men. During the LS teasing took place between the men and the staff, between the men and between the staff. But here, Joseph appears to be describing something different as he singles out three or four staff who "take the mickey", suggesting that what they do it is not common to all staff.

The functions of such repertoires may be to show some of the staff as cruel, as he differentiates these few staff from others. It demonstrates the difference between teasing for humour, which is common in the data, and the teasing Joseph describes here. He also describes it as happening to others and not him; "of other patients and that", in which Joseph puts himself as an observer who describes how it is. This could be a way of telling the story, but also saving face as the staff are teasing other people, but not him. The functions of such repertoires are to suggest that staff are not professional and may be using humour in a destructive way; this does not show them in a good light and confirms the men as victims. They include ideologies opposite to that of the 'good nurse'⁹⁵ and legitimate mistrust and dislike of the nursing staff by the men. The men can also be viewed as passive and lacking in skills.

⁹⁵ Please see later for 'good nurse' characteristics.

Repertoire #4 – The men are passive victims

The men are regarded as dangerous and security as paramount for the safety of everyone. However, paradoxically, the men are also seen as people who are lacking basic skills and understanding:

The men find it hard to understand simple tasks

"I just think it's a nightmare of a task because it will be so hard. It's just to make them [the men] understand, sometimes, the simplest of things, you know. Never mind... Even folding their pants or their shirt or... Pairing their socks up to get proper pairs of socks."
(Staff Session)

The staff member is discussing the difficulty envisioned for the men in understanding the complex concepts involved in research. It contains ideologies of inability and deficit and functions to show how impaired the men are and how difficult it is for the staff.

The men are seen as passive patients

Such repertoires represent the men as people without an opinion, who are passive patients who cannot give consent. These ideas also exist in the MHA (1983) and have seeped into local policy and legislation:

'This Trust has a particular duty of care towards detained patients which extends to protecting them from undertaking harmful activity which may be an expression or influence of mental disorder or mental impairment. ...It is therefore not in the interests of either group that they be exposed to or are allowed to express sexual behaviours that may be exploitative or coercive, or where detained patients are not in full control of their sexual behaviour. There is the further issue of valid consent in the group of patients who are detained because of a mental disorder and/or impairment under the Mental Health Act.' (1983, Sexual Relationships policy, 7)

Further, in the following example the staff use the term "give them" instead of using terms like empower or help. It is a very task-oriented response, the men and their activities are tasks to be fulfilled, where staff are viewed as imparting skills to the men and the men as passively accepting:

"I help in their daily tasks and we take them to work sessions and sort of give them daily living skills and where possible socialising skills... Well, starting in the morning we get them up, get their breakfast, obviously security is always a sort of issue here you know you have to count cutlery, and things like that, pens aren't left lying around, you have to check toiletries out and in, room searches are done on a daily... sort of weekly basis, visitors are checked when they come, erm... they have telephone calls, they attend work sessions, they come back for drinks, you know tea breaks, coffee breaks, then you do lunch again work sessions or they could be occupied on the ward or they may be doing social training or they may be doing tasks on the ward, cleaning or something, their own rooms and things like that, or washing, ironing, you know, sort of things like that." (Staff 5)

These were ideas which were also understood and expressed by the men:

"It makes me feel that I've got no control on looking after myself. It's just like your parents bringing you up when you're a child. It feels like that. But I'm saying, well, I'm no child. I say I'm old enough to make my own decisions and I don't need that sort of, like, thing, like banner over my head saying that I've got a learning disability, we're going to take control of this patient now." (Matthew)

These repertoires hold ideologies of deficit, of control and of how the staff know best. They contain assumptions, expressed by policy and participants, of the men's need for protection and control as they cannot control themselves. Only security can control their behaviour and protect people. Such repertoires function to legitimate over-protection and restrictions placed on the men. Here, Matthew rails against such ideas expressing the stigma and prejudice attached to having a learning disability.

The men are victims and vulnerable

SRV showed that people with a learning disability are the most devalued in our society. Therefore, they are also most vulnerable to inhumane treatment. Similarly, they are commonly represented as vulnerable to abuse and exploitation, and as victims. This theme runs through policy and is expressed by the men who, paradoxically, are also seen as dangerous perpetrators:

"Because there's a lot of people with learning disabilities as I've noticed who can't say no. And they get too involved in things with, like, saying where they'll not say no and it's like a form of a bullying type thing... And they just go ahead along with it... And really, they don't really want to do that. And they just won't say no, just in case... I've seen it in the hospital you know, like, with people with learning disabilities that have been drawn into something that they wish they had never been drawn into. Because they'll get into trouble." (Matthew)

'...and people with learning disabilities do not always receive adequate protection from abuse and exploitation'. (Valuing People, DoH, 2001, 8.2)

'Many organisations and individuals are concerned about the inappropriate use of physical interventions with adults and children with learning disabilities'. (Valuing People, DoH, 2001, 8.15)

'...Many of the patients detained at [Trust name] are themselves vulnerable and have been the subject of sexual and other abuse'. (Sexual Relationships policy, 7)

Here the policy states that the men's perceived vulnerability is used as a justification for their not being allowed to express their sexuality.

Perceived vulnerability leads to lack of control

The belief that the men are vulnerable may lead to paternalistic treatment and over-protection.

This is a view which the men also hold.

"...if you were living on your own and you had no back up and nobody around you and you were like stuck in the middle with a load of gang of lads around you, wanting money off you or something, you know. You can't just, really, say no. You just have to give them it because you're on your own. You haven't got anybody to back to up. To help you support you." (Matthew)

"It makes me feel that I've got no control on looking after myself. It's just like your parents bringing you up when you're a child." (Matthew)

'Others are detained precisely because they have offending histories against particularly vulnerable people. It is therefore not in the interests of either group that they be exposed to or are allowed to express sexual behaviours that may be exploitative or coercive, or where detained patients are not in full control of their sexual behaviour'. (Mental Health Act, 1983, Sexual Relationships policy, 7)

Such repertoires serve the function of inducing pity, which leads to justifications for shelter and control. This is reminiscent of medical and personal tragedy models and justifies restrictions on the men's personal behaviour. There are assumptions of inability and ideologies of the medical profession knowing best and becoming powerful protectors of the men, even protecting them from themselves⁹⁶. The repertoires suggest that those using them believe that it is the men's impairment that makes them vulnerable and not their disablement, illuminating the stigma and prejudice associated with having a learning disability.

Repertoire #5 - People should not be living in NHS Long Stay Hospital premises/the MSU

Policy and Practice suggest the men should not be held here

Nurses for people with a learning disability are trained generally to work in the community and have beliefs about people with a learning disability having the same rights and life chances as everyone else:

Interviewer

And what would you say is the biggest improvement? [In nursing people with a learning disability]

Staff

The movement of people from residential units into the community, definitely, yeah. (Staff 4)

Here the staff member is discussing the view that people should not be held in institutions. The staff members currently work in a secure unit – so on one hand they are saying the biggest improvement is people living in the community, whilst simultaneously detaining others in a secure unit. Similar sentiments are expressed in policy:

⁹⁶ Despite its appearing that the men have not been protected well so far, otherwise they may not be residing in the MSU.

'For almost 30 years, successive Governments have been committed to the re-provision of long-stay hospital accommodation in order to enable people to live in community-based housing. However, there remain over 1500 people living in old long-stay hospitals. In some areas, the long-stay hospitals have been partly replaced by NHS residential campuses often on former hospital sites or in NHS homes in the community.'

'While people with learning disabilities, like other people, may need to be admitted to hospital on a short-term basis, we do not believe it is right for them to live in NHS hospital accommodation on a long-term basis.' (Valuing People; 7.17)

Such repertoires function to differentiate the men's treatment from normal and suggests that the men should not be living in hospitals long term - but these men do and will continue to. The exception appears to be those with challenging behaviour/offenders who can live in premises considered unsuitable for others with a learning disability. Such repertoires differentiate the men's treatment from the norm, from other offenders and from other people with a learning disability.

The men feel that they should not be held in the MSU

"You know, they often say they shouldn't be here or they don't want to be here, they miss their families, they miss their life before but obviously that's been a life of crime too, you know, so they have to be away from society, you know, I couldn't say the positive [aspects of being on the MSU]." (Staff 5)

Despite working on the MSU, this staff member cannot find anything positive to say about it. The participants made assumptions regarding the men's guilt and the men's feelings. Functions of such repertoires include recognitions of staff empathy and show the MSU as a negative place, but a place where the men are justified in being. People are held in the MSU for their own good, and are considered to be in need of treatment in a compulsory manner in medium security to protect them from themselves. The men would find it difficult to serve their term in gaol and they require treatment. People are also held in the MSU for the protection of others; they are seen as dangerous criminals, sex offenders, violent and difficult to manage. Therefore, legislation and the code of conduct (2002a) compel nurses to protect society from them:

"Erm... (pause)... again cos we're a medium secure unit it's difficult. We give as much choice and empowerment as we possibly can amongst the restraints and we're governed by policy and procedures and the Mental Health Act as well." (Staff 4)

This is an important argument that illustrates how the staff are also compelled by legislation and policy, as well as the men.

People with a learning disability are more commonly victims of crime and vulnerable to abuse. Therefore, they should possibly not be detained a long way from their family and friends amongst other offenders. Removing vulnerable people from their support mechanisms and placing them among convicted offenders increases that vulnerability, especially when they are not held in local services. The men come from very disadvantaged backgrounds, often including neglect or abuse, and are much less likely than the general population to be convicted of crimes. When they are convicted their crimes are commonly less violent than those of their non-disabled counterparts, so justifying their detainment in this way may be problematic.

The next section explores the behavioural expectations of the men and the restrictions and rights that they have.

Paradox 4 – Low expectations of the men- High expectations of the men's behaviour

Expectations of Behaviour

"Like surveillance and, with it, normalization becomes one of the great instruments of power... For the marks which once indicated status, privilege and affiliation were increasingly replaced... by a whole range of degrees of normality indicating membership of a homogeneous social body but also playing a part in classification, hierarchization and distribution of rank" (Foucault, Discipline and Punish 1975, 184).

Paradox # 4 – Low expectations of the men – high expectations of the men's behaviour

- The men are seen as having few skills and little understanding – yet there are high expectations of the men's behaviour which is observed and policed

The men have few skills and little understanding

In this paradox the men are expected to behave almost too well, whilst simultaneously including low expectations of them and their skills and understanding. Yet, when they do behave accordingly the rewards they are entitled to are not always available. Thus, they have to behave in a certain way, but the staff team does not receive sanctions for not keeping their side of the contract. Lots of examples of arguments of inability have been given already so this paradox will be discussed only briefly:

The men need to be constantly supervised because of their potential dangerousness

*[discussing the men having to be escorted whilst being interviewed for the research]
"Well, like I say, it just depends on the situation, the interview and everything, do you know what I mean. If you're a woman and interviewing that [man you are interviewing] doesn't really like women you have to have somebody there for security reasons, you see. You've got to be careful..." (Staff 2)*

The staff member justifies staff being present at the interview by using specific examples of a man who doesn't like women and this functions as warnings to others and helps to justify surveillance and security. Security is seen as of great importance in the MSU.

Other men were viewed as disruptive:

"Patient's behavioural problem depending on which patients are going to be involved er... I can think of a couple of patients now who change like the weather and could be very disruptive to others and spoil the whole session and who would have to be removed from the session." (Staff 9)

[when asked about the men joining in group work]

"But you've got to remember it's a secure unit so they've got to be supervised all the time. You've got to be careful because of what people are here for." (Staff 2)

Ideologies of dangerousness, especially to women, and the unpredictability of the men are being peddled here.

Staff have low expectations of men's behaviour and understanding

When asked whether people with a learning disability should take part in research the staff commented:

"Take part or be researched? It depends which people you're speaking about cos [because] I mean there's... learning disabilities range between people who are quite able and people who are very disabled and I think it would be difficult for some of the people I've worked with to do any kind of research at all. It depends on their understanding, you know, you couldn't do it with everybody... I think they have to have communication skills themselves and a decent understanding, quite good language (pause). And I think they've got to be willing to participate, their behaviour has to be reasonably settled, it's not going to be any good if we get somebody who'll come one week, miss two weeks, one week or be disruptive to other people." (Staff 7)

"Very much so and there's some... a couple of patients who I know erm have a lot of difficulty understanding anything even simple things... so if it was going to be anything even mentioning research, most of them wouldn't have a clue what research was." (Staff 9)

The criteria which were expected to enable the men to join in research were not only academic, but behavioural too:

"I think there's certain ones who would have been very disruptive. And it would have had a negative effect on the rest of the group. Those who have difficulty tolerating their peers, let alone interacting with them sensible in a research project... And who's got concentration levels and how they get on with other patients. And what are their levels of understanding? And what they would get out of it." (Staff Focus Group)

Such repertoires include discourses of deficit, dangerousness and unpredictability. The staff are shown as experts who can judge whether the men deserve restrictions or privileges. The expectations of the men's ability are low, whilst expectations of behaviour are paradoxically high⁹⁷ - security and restrictions are legitimated under the rhetoric of treatment.

⁹⁷ High expectations of the men's behaviour are an important aspect of their treatment.

High expectations of the men's behaviour

Hamilton and Manias (2006)⁹⁸ refer to the Foucauldian ideas of governmentality, which they define as the ways in which nurses use 'mechanisms of power' (page 86) to create and maintain their behaviour. One such mechanism of governmentality is 'normalising judgements'⁹⁹, by which nurses can create and maintain views of themselves through language and one in which they can judge the behaviours and standards of the men. The grading system is a very important part of the routine in the MSU, and relies heavily on such judgements in everyday practices, such as nursing notes. It is an important part of the security and treatment.

The Grading System

The grading system is a local policy which all of the men follow. It has a point system where the level of behaviour is measured by the "grade" which they are on. This grading system works on the principles of token economy; they begin on the lowest grade with few choices and few responsibilities. If their behaviour warrants it they can move up through the grades (a clinical decision) and receive more choices and more responsibility. Depending on the severity and frequency of their behaviour they may move down grades and lose privileges; they may move more than one grade down. It is possible to behave well for many months and to behave so severely that the grade is lowered from grade 6 (highest privileges) to 1 - the lowest grade. Such a jump up in grades is not possible. There are also choices that are restricted by their section, and by the Home Office, depending upon their offence history and their perceived risk. Security is required to pervade everything in the MSU because of the men's dangerousness. A large part of the staff's role in the MSU is around surveillance. This serves two purposes; treatment and security.¹⁰⁰

⁹⁸ They studied nurses' use of language and what it produces in terms of their relationships and power.

⁹⁹ These are ways in which nurses create their normal and acceptable standards and then use strategies to exclude or correct behaviour which does not meet the normal standard.

¹⁰⁰ The men are considered a risk to others and themselves and, therefore, they need to be observed for most, if not all, of their waking hours. The men also have treatment plans and part of their treatment includes the grading system which relies upon the surveillance of the men and the staff reporting and recording appropriate and inappropriate behaviour.

There is a high expectation of behaviour

Sometimes this behaviour may appear more than we would expect of ourselves - to behave well week after week, with no slip-ups (or they may be downgraded). This appears all the more surprising when there are low expectations of understanding, mental health and behaviour attached to the men.

Grading system is a reward system

"It's like for when they behave they like move up." (Staff 3)

The staff member begins by saying it is a reward system; then goes on to explain the way it is used for punishment:

"It's like a red and yellow card. Red card they automatically get dropped to grade one, if they try to hit staff or there's like various things. They have yellow cards and it's like a warning system, you know, and it works quite well." (Staff 3)

Then back to the rewards, which are simple "privileges" that we take for granted; free time listening to music, watching DVDs and cooking:

"If they like if they have a good day anyway, they have their free time, they have a choice to go in their room, they have a choice what they want to do in their room, DVDs, videos, CDs, erm, and they have choices at the weekend about what they want to cook. Although that's choice within a group, at the weekend staff cook food and do stuff with them and if they wanted to cook with us, they can cook with the staff, the same as any time during the week if there's nothing on, you know." (Staff 3)

Such statements carry beliefs that the men require constant observation and judgment by the staff, and that the staff have the right to take away privileges from the men¹⁰¹. Such discourses assume that the staff are fair and non-judgmental and are able to judge behaviour.

Repertoires of the grading system have rhetoric of treatment attached to them which legitimates the withholding of privileges to encourage behaviour deemed acceptable and enables a punitive system if those standards of behaviour are not met. They are linked directly to the restrictions on rights that the men experience and will be addressed next.

¹⁰¹ There is guidance on such matters; Mental Health Act Commission (1999).

Paradox 5 – The men are entitled to rights as everyone else – the men's rights are restricted

Repertoires of Rights and Restrictions

Paradox 5 - The men are entitled to rights as everyone else – the men's rights are restricted

Repertoires of Rights

1. **National law and policy state that the men are entitled to same rights, choice, consent and privacy as everyone else**

Repertoire #1 - National law and policy states that the men are entitled to same rights, choice, consent and privacy as everyone else

"You get loads. You get loads of choices. You come up with your work sessions... Then, you can go and clean your bedroom and you can take as long as you want. You can take a CD up or watch a bit of telly in your room and listen to a bit of music while you're doing it. And then afterwards, after you have finished, you would the stuff round and then that's basically, it's like, if you want to go back to your room you can go and lie on your bed and listen to your music some more... And they'll come and get you later on when you can come down for a drink. And after that, you've got nothing else to do so it's like, right, whatever you want to do it's yours, do it... Freedom of rights represent a load of things. Freedom of speech, freedom to speak out. Freedom to make a choice. Freedom to do whatever. Plus free will is the strongest thing on the planet." (Luke)

Luke is stating enthusiastically all of the rights and choices he has in the MSU. Policy similarly states this, but there is little mention of the constructions of such choices - which are in the hands of the staff and policy makers:

Policy states that the men are entitled to the same rights and consent despite treatment

'A proportion of people with learning disabilities will require intensive health care support through...over a prolonged period of time because of their complex disability or the challenges they place on services. Such people have the same entitlements to independence, choice, inclusion and civil rights as all others.' (Valuing People, 6.32)

The operational policy of the MSU clearly states that the men should be deemed to be able to consent unless certain criteria are fulfilled.

'Capacity has been defined by the Courts and is summarised in paragraph 15.10 of the code of practice Mental Health Act 1983. This states:- "an individual is presumed to have the capacity to make a treatment decision unless he or she:- is unable to take in and retain the information material to the decision especially as to the likely consequences of having or not having the treatment; or is unable to believe the information; or is unable to weigh the information in the balance as part of a process of arriving at the decision."'
(Operational Policy, 3.1)

Ideologies of these repertoires include human rights; capacity to consent; inclusion and independence; and that capacity should be tested, not assumed. National policy clearly states that people with a learning disability have rights to choice and control over their lives, but concede that few people do:

'Our new agenda needs to be based on social inclusion, civil rights, choice and independence. People with learning disabilities have the right to be full members of the society in which they live, to choose where they live and what they do, and to be as independent as they wish to be.' (Valuing People, DoH, 2001, 1.1)

They legitimate independence and no restrictions on the rights of people with a learning disability. However in reality they concede that

'Many people with learning disabilities have little choice or control in their lives. Recent research shows only 6% of people with learning disabilities having control over who they lived with and 1% over choice of carer. Advocacy services are patchy and inconsistent.'
(Valuing People, DoH, 2001, 1, 1.18)

Similarly Matthew states:

Matthew

"Well at the minute a lot of the patients have got advocates to make their own decisions for them but if they can get away from advocates and be a bit more independent then they might benefit from that."

Interviewer

"So sometimes advocates can help make choices but maybe they should be able to make them on their own?"

Matthew

"Yes". (Matthew)

Such arguments function as rhetorical claims that people with a learning disability can exercise the same rights as everyone else when little heed is paid to the construction of those choices by people in power.

The men are afforded privacy

For example, the men are afforded some privacy in written correspondence:

"...you know, personal letters are kept confidential, they don't have to show you what's in them kind of thing." (Staff 5)

Such repertoires show that the men do indeed exercise some basic rights as above. However the repertoires of restrictions are more numerous.

Repertoires of Restrictions: the men's rights should be restricted

Examples of rights withdrawn

Basic Rights are withdrawn

The restrictions placed upon the men include the most basic of choices such as access to money, work and movement:

[when asked what other choices they would like]

"More access to carry my money around. More leave in the freedom sense. Like, an example being, I would like to be able to walk out that door and get told to be back at a certain time and just go off. Come back later... I would like to go on overnight stays, but at the minute I can't." (Luke)

"More free time. More independence. You know? More choices in, like, going out to the club. Going to work, you know? Mainly more choice in, like, saying to get out and do your own shopping. And a choice in, like, saying, well, like, how much money you want to spend while you're out. Not just like a set amount, you know, what they say." (Matthew)

Please note that these arguments come from the men and have ideologies of trust and choices being withdrawn. They legitimate the men's complaints regarding restrictions on rights and choice and function to illustrate to the listener that the MSU is a restrictive facility.

Consent is withdrawn

The operational policy clearly states that the men should be deemed to consent unless otherwise proven. This is usually a clinical decision but one which may not always be fully understood by the staff:

"In conversation with one of the men today, he was recalling how he felt that he fully understood issues of consent now [after taking part in the LS]... After recalling the issues [to do with consent] discussed in the workshops he went on to tell a story of what had happened on a recent visit to hospital... when... a consent form was to be signed for treatment he should have received that day. However the staff who was escorting him suggested they return to the unit to get the consent form signed. The man protested, insisting that, after asking a number of pertinent questions about the proposed treatment, he could and did consent... and began explaining the pros and cons of the treatment... that he fully understood and consented. Much to the man's disgust and surprise the member of staff disregarded what he said... insisting that he could not consent... and

returned him to the MSU for consent to be obtained in a different way. On reflection, it appeared to me, that it was the member of staff, and not the man, who did not fully understand informed consent.” (Researcher, Field notes)

By the end of the LS the men really did understand consent as this quotation from Mark illustrates:

*[when asked what he would do if he was asked to participate in research]
...[I’d ask] What it’s about, what it contains, what are the risks, what are the health benefits, how much you are going to pay me!... [with humour]... And make sure that I’ve got all of the texts and stuff that I need so I can make an honest and reasonable and an informed decision. (Mark)*

Dignity and Privacy withdrawn: the men are constantly observed

These repertoires contain ideologies of incompetence of the men and of security being of the utmost import; the men cannot be trusted and security, which lowers risk, is therefore good for all. Here Matthew is describing the constant observation and control over his movements imposed at the MSU:

“...And then you only get, like, your free time on a night time, but that’s for an hour. And that’s it. You can’t really just say, “I want to go off to my room” on a weekend. And just have free time. Because they’re saying if you do that then a member of staff has to be observing you having your free time. So they can’t really afford to make the staff go out of the day room, up onto the landing to watch the lads have their free time [because of staff shortages].” (Matthew)

Security pervades everything the men and the staff do, and was considered a great part of the staffs’ role and impacted on every part of their duties. Repertoires such as this express ideas about the pervasion of security and too many restrictions being placed on the men. It shows the men as being treated unfairly as they do not receive freedoms which they are entitled to.

Restrictions are linked to security

National law and policy reflect the need for security to protect people from themselves and others, and to protect others in society from the men. The provision in the MHA (1983) for people with a ‘mental sub-normality’ allows people with a learning disability to be held for specified periods of time whilst fulfilling certain clinical criteria for treatment. Security is of high importance in these repertoires. The MSU is the middle ground for security; sitting between low and high security settings:

“But you’ve got to remember it’s a secure unit so they’ve got to be supervised all the time. You’ve got to be careful because of what people are here for.” (Staff 2)

Such repertoires contain beliefs that the men can’t be trusted, that security measures lower risks from the men and are for the good of all; they justify restrictive practices, treatment and reduction of the men’s rights.

National policy states that the men should be entitled to their rights, including privacy whilst in the MSU. Here, Joseph describes how he has to ask permission to visit the toilet:

"Well, we're always asking to go to the toilet and stuff like that... Aye. So they know where you are and that. But apart from that I don't think there are much choices. Much other choice." (Joseph)

The men do not have privacy of space, as conversations are frequently overheard:

*[talking about private conversations]
"It could get broadcast that way. Because I mean that don't know who's passing by at the time."* (Joseph)

Such repertoires have implicit ideologies of incompetence being assumed in the men, and legitimate treatment without consent. The men's opinions function to argue that they should have greater freedom of movement, money and privacy, and appear reasonable but do not take account of the risks that the men may pose.

Repertoires of Restrictions: the men's rights should be restricted

- 1. Legislation and local policy restricts rights and choice (authoritative corroboration)**
- 2. Restrictions of basic rights, choice and consent justified because of the men**
- 3. Restrictions of basic rights, choice and consent justified because of the staff**

Repertoire #1 - Legislation and local policy restricts rights and choice (authoritative corroboration)

There are many more repertoires regarding restrictions than there are regarding rights afforded the men. There are overlaps in legislation and policy as, for example, national policy states that the men should have the same rights that others are entitled to; but the MHA (1983), local and national policy enable (and even compel) nurses to withdraw rights and choices of people held under certain sections for specified periods of time. There are numerous uses of authoritative corroboration in such repertoires meaning nurses are compelled by duty and legislation to restrict the men's rights. Local policy dictates that the men are not entitled to privacy in the most sensitive of activities:

'If it is known or suspected that such contact [sexual contact between the patients] has occurred, staff will respond according to the nature, severity of the situation and its contextual factors. In all cases, a Risk Assessment will be carried out immediately after any more pressing issues have been resolved, and the incident will be reported to the Villa Management of the respective patients.' (Sexual Relationship policy, 11)

'Private individual masturbation is permitted in that individual patient's bedroom only, provided that appropriate steps have been taken to ensure that this is not likely to be witnessed by other patients or the public. This should involve discussion with nursing staff. Masturbatory aids other than prescribed lubricants and any other stimulatory material such as pictures are not permitted.' (Sexual Relationship policy, 12)

Such repertoires include ideologies of the men as sex offenders and that in certain circumstances the staff have governmentality over human rights - which may be withdrawn.

The lack of choice for people with a learning disability may be as a result of national and local policy, which despite proclaiming the need for choice and control for people with a learning disability, use authoritative corroboration to justify lack of choice and their detainment. The following is an example which illustrates the authoritative corroboration used in only five sections of the Sexual Relationships policy which functions to justify the restriction of rights:

- *the Mental Health Act Commission (2003) Tenth Biennial Report 2001*
- *European Convention on Human Rights as expressed by the House of Commons, House of Lords, Joint Committee on Human Rights (2003)*
- *The case for a Human Rights Commission: Sixth Report of Session 2002-03*
- *The Sexual Offences Act (2003) and the Mental Capacity Act (2005).*
- *Article 8 of European Convention.*
- *Mental Health Act Commission (2003)*
- *R v Ashworth Hospital Authority ex p RH (2001)*
- *The Mental Health Act (1983)*
- *The Sexual Offences Act (2003) (Sexual relationships policy, 3 – 8)*

Repertoire #2 - Restrictions of basic rights, choice and consent justified because of the men

Choices restricted because of the men's ability and security

The rights of those in the MSU are determined by staffs' clinical judgement as to whether the criteria for consent and choice are satisfied:

[Asked how they feel about choice and empowerment for the men]

"Definitely. It's a good thing. I think they have to make choices, definitely. Even if it's down to their own food that they eat, their meals and everything, I think it's important to have choice... Well, it's just the way that life isn't it? Everybody has to make choices as long as they are ok to make choices."

Interviewer

"And how would you define whether somebody was ok to make choices?"

Staff

"Well, that's a hard question this isn't it, really. Em... You've got to make choice with communication so you have to be able to communicate before you make a choice. It's knowing the patient really, how they work... not how they work but how they live. The day to day living, it's knowing your patient or your client or whatever and how they want to make choices cos there's hundreds of different ways you see. Some people can't speak so they might shout or bang their head off the door. See what I mean, it's hard to really explain." (Staff 2)

The staff member begins to explain the importance of choices for the men. This continues with qualifying this idea with certain criteria. These criteria are not always easy to identify - "As long as they're ok to make choices". Here, their ability and their security risks are being discussed. The reference to "know your patient" appears to be part of this decision as to whether they are ok to make choices; knowing their risks and abilities, presumably. This hints of governmentality and carries the belief that choice is important but requires a certain level of ability in the men, which staff can measure - not something in law which we are all entitled to and which is legitimate or reliant upon staff employing different methods of enabling choice. There are underlying ideologies of "the staff know best" and are able to judge, which legitimate the staff's ability to craft and restrict choices.

Choices restricted because of their grade, behaviour and section

There is a strict regime of timetabled activity on the MSU and this, it is argued, is required because:

1. it has been historically missing in the men's background
2. boredom may lead to bad behaviour

Justifications for such a strict regime include:

"Well, you have to have structure and most of them [the men] aren't used to structure and occupying them too." (Staff 5)

Most of the men come from dysfunctional and complex families, and often the MSU offers the first real routine they have ever had in their lives. There are beliefs that the men require a sound structure in their day and the very strict regime in the MSU is justified because of the men's apparent need for routine. The staff report a structured day to be important as the men might get into trouble if they are not occupied:

"...giving them something to do because boredom is something that is you know, very easy... their mood changes very easily when they have got nothing to do so you try and keep them cheerful and give them something to do and teach them at the same time little skills and different stuff within the day. I mean that's structure, but it's not something that you think about, but it's a structured day... 'cos if you just left them to their own devices they wouldn't be getting out of bed, you know, the whole day would be totally upside down kind of thing and if they haven't had structure before you know a certain structure is very good for them." (Staff 5)

Such repertoires demonstrate beliefs that a strict regime is treatment for complex or dangerous behaviour and such restrictions on them are for their own good. These ideologies agree that it is right

that there are certain choices that the men can't have because of their behaviour¹⁰² and risk. There are also choices that are restricted by the section of the mental health they are held under, and by the Home Office, depending upon their offence history and perceived risk. It is believed that it is the nurses' duty to restrict the men accordingly and such beliefs legitimate the control and restriction of the men and their rights. It is further justified because it is believed that it is the men's own behaviour which dictates each restriction; if they had not offended they would not be on MSU. Furthermore, there is a belief that their behaviour predicts their grade, the section of the MHA they are under and, therefore, the restrictions they experience too. It appears obvious that choice here is used in its rhetorical sense to conceal power – the power of others to decide which choices may be available to the men¹⁰³.

Choices restricted because they have to consider others

Another reason why choices are restricted appears to be consideration for other men they share the unit with:

"[they have a choice about] Most things, lots of things. But, of course, like I say it's within reason... about what activities they want to do on a day to day basis but for instance this is a six bedded unit erm... if six of the individuals wanted to do six different things on each day, that would just be impractical and almost impossible to staff... I think the balance is right between choice and what is practical." (Staff 2)

Choice is important, but there should be a balance between choice and "what is practical" – i.e. the risks and staffing issues. The activities and choices have to be balanced with the risks "within reason". However, such arguments illustrate beliefs that choices should be restricted and staff may decide what is reasonable. It functions to restrict choice which is justified because it is for the good of the majority who reside in the MSU.

Choices restricted because the men don't like too much choice

There is a belief that restrictive choice may be for the men's' own good as it puzzles them, makes them unhappy and they may make what may be seen as the wrong choice:

"Sometimes when the patients are getting a lot of choice sometimes it confuses them. Sometimes it makes them unhappy. Sometimes they like the facts. Sometimes a lot of information they can't take it in, you know... Sometimes they're decision might be the wrong decision." (Staff 3)

¹⁰² The level of the men's behaviour is measured by the 'grade'.

¹⁰³ As discussed in Parker and Burman, 1993.

This repertoire exists in policy and includes beliefs that wrong decisions are something that may be judged by the staff and holds assumptions about the men's inability and mistrust - the men must be protected and, again, this legitimates the restriction of choice.

Repertoire #3 – Restrictions of basic rights, choice and consent justified because of the staff

Choices restricted because of the staff attitude

Important meetings and opinions are reported to be dominated by staff:

Matthew

"They [staff] don't tend to take any notice. It's like they're qualified when they see the doctor before you – which I find is wrong. You should be able to see the doctor, when he comes, before the staff have their say. It's like the case reviews on you as well... which is all wrong. The staff are in there before the patients. You only go in the last 15 minutes. Outside you sit in through the whole lot and on the ward before I came here, you know, you could actually see your doctor before the staff see your doctor. So that worked better. Or you could be there when the staff are seeing the doctor. If there's anything [untoward] you could say, "Well, hold on a minute." I say, "I know what's what [and] that's wrong. What you're saying [is wrong]. Can we just rephrase it in the right way, please?""

Interviewer

"So you think that when they see the doctor before you they might be saying things about you is that what you mean?"

Matthew

"Yeah. Which they tend to do that." (Matthew)

Matthew believes that it is the staffs' attitude which restricts their choices.

Matthew

"Probably [it would be better if] some more work [was] done with the staff. Like, put them on a course for them to learn how to communicate better and give more choices and listen more openly towards the patients."

Interviewer

"Right, so you think it's staff attitude that stops you having choices?"

Matthew

"Aye." (Matthew)

This argument has assumptions that the staff require training and that the staff don't listen. It holds beliefs that it is the staff, and not policy, legislation or their behaviour, which restricts the men's choices. It functions to enable the men to escape any responsibility and blame individual staff for the current restrictions on their lives.

Choices restricted because of staff training and experience in the MSU

What Matthew says is backed up by reports from the staff; the amount of choice sometimes depends upon which staff member is offering it::

"But again, of course, because of security reasons for dangerousness to themselves, harming themselves or others, that can be limited and there are security issues on the unit. We do our best that we can to get that balance right and depending on your particular viewpoint as to where you lean [between security or therapy]. I think being fresh out of university if you like [a newly qualified nurse], I would like to think I lean more towards the therapy than the security side but I think if you look at those who have been in a secure setting for longer then they may focus on the security side. That's just my observations." (Staff 1)

Such repertoires have assumptions that staff are able to balance therapy and security and rest on ideologies such as that security needs to be balanced with therapy and education changes attitude. They legitimate the staff being able to choose whether therapy or security is more important at any given time.

Choices restricted because of Staff shortages

"It's like getting out of the club [the hospital patients have a social club of their own]. You can't get out of the club neither, because they're short staffed. It's like work placements are being cancelled because we need staff to take us over there." (Matthew)

Such repertoires function to show that it is not merely the men's behaviour which dictates restrictions and liberties, but staff attitude, skills and training. Repertoires claiming it is correct that rights are restricted because of the staff, legitimate the staff not rewarding the men for approved behaviour. Yet, the men are downgraded for opposite behaviour. It would be interesting to discover whether this works the other way and the men are not downgraded when necessary.

Policy restricts rights not the behaviour of the men

"I would say yes, because at first, they [the staff] were stricter like they [the men] had to attend work even if they don't participate whereas now, you know, it's very much fine if they don't go to work [placement], ok - except you're [the men are losing money if they do not attend work] losing money - you know but you look at why there are issues [with the men not wanting to go to work] and what is wrong and find out what is going on [rather than just reducing their pay] (long pause)." (Staff 5)

This repertoire shows that the staff are not merely punitive, but try to find reasons why the men might not behave as they should. Such arguments involve ideologies that restrictions are the fault of the men's personal behaviour. Yet, importantly, the types and level of restrictions change with policy and depending on which staff are on duty. This calls into question the belief that it is the men's own fault but still legitimates current restrictions as fair and progressive.

Policy is changing to offer more choice to the men detained in the MSU:

Staff

"...we've had to make choices for them in the past."

Interviewer

"And that's something that's shifting?"

Staff

"Aye, definitely shifting." (Staff 2)

"Rule wise and what they could and couldn't do, you know, it's gone more in their [the men] favour kind of thing..." (Staff 5)

This suggests that it is in the staff's favour for there to be a strict regime. A great deal of the restrictions placed upon the men and the staff were linked to security. This repertoire functions to show that it is not as strict as it used to be/should be:

"...it's not as strict as it used to be in many ways but still in the boundaries of a medium secure unit, you know, so maybe the grading system has changed for example for the better for them, they can keep things like electrical things in their room which when we first opened they couldn't do at all, you know, even on grade five and things but a lot of the time they can keep electrics in their room and things. You know, they have sweets and they keep them in their room at certain grades, they have incentive and things so, you know, it's changing all the time, it doesn't stand still, you know, it's not going to be the same in ten years time there'll be something else happening." (Staff 5)

The whole of the security routine is justified because of the men's behaviour and risk. This staff member is describing the way that the strictness of the regime is changing, but the types of men that are detained are not. It may be, in fact, that policy dictates the regime and not the behaviour of the men and in this sense the staff are subject to policy changes too. Such repertoires function to suggest that the MSU is progressive but this argument acts against the many arguments that the restrictions are the men's own fault and because of the men's behaviour, as policy can change the restrictions not just behaviour. Significantly, it may be policy and not individual treatment, men's behaviour or the staff, that dictate the restrictions placed upon the men.

Unfortunately this appears to be an ongoing debate in terms of security in forensic settings where policy restricts security and rights of the inpatients and the staffs' hands are often tied on such issues.

As Kirby states:

'Invariably there are cases where security is sacrificed in favour of the therapeutic activity and unnecessary and unfortunate incidents occur, or the need for security outweighs the therapeutic value of an intervention or action and the patient makes no clinical progress.'
(Kirby, 1999; 300, cited in Dale and Gardner, 2001; 256)

This is a complex issue for the men and the staff and is discussed in depth in the next chapter.

Summary

This chapter is concerned with security and the experiences of the MSU by the staff and the men. It has discussed the findings and interpretations of three paradoxes: positive and negative aspects of detainment; behaviour and expectations of the men; and the restrictions of their rights. The experiences of living in the MSU include negative issues of detainment where the men report being bored, over observed and overly controlled by the staff and the regime. There are lists of things which one cannot do in the MSU¹⁰⁴; and these restrictions are justified because of the men's risky behaviour, but there have been historical shifts in levels of security which are nothing to do with the men's risk level.

Lack of privacy is another issue which negatively affects the men on the MSU. For example they need to ask to go to the toilet, have little private space, lack privacy from the staff in some meetings and their sexual activity is restricted and controlled. The staff report that they are afforded privacy in personal letters. The men have a grading system, which is used to reward them for good behaviour with extra money, privileges and choices.

Policy is confusing in this area¹⁰⁵, stating that the men should have the right to choice, but admits that in reality people with a learning disability, generally, have restricted choice. The men are presented as being restricted in choice for their own good – some of them are basic choices such as choices about money, work and movement¹⁰⁶. The men claim that the level of choice given depends upon the staff on duty and this is confirmed by other staff. Also, choices change over time, meaning that their restrictions may be less to do with the men's risk and more to do with policy and regime change. The decisions about choice and consent rely upon the clinical judgements of staff, but they find it difficult to articulate the criteria that they use to judge these.

This chapter illustrated ideologies, assumptions and functions of the repertoires and arguments chosen. It appears that security is dominated by repertoires of the governmentality of the staff and

¹⁰⁴ The staff report that the regime is changing in the men's favour. However, there remain many restrictions due to security and risk.

¹⁰⁵ *Valuing People* states that people are entitled to privacy, but local policy, backed by the MHA (1983) and The Sexual Offences Act (2003) and other legislation, advocates for control over sexual behaviour.

¹⁰⁶ Authoritative corroboration is used to justify the choice restrictions.

discourses of dangerousness of the men which justify restriction of rights, choice and privacy. However, contrary discourses exist in which the staff are as restricted by policy as the men.

The next chapter explores the relationship between the men and the staff further by exploring paradoxes and ideologies underpinning forensic practice and the nurse/patient relationship.

Chapter 8 – Forensic Practice: The Security-Therapy Paradox

'One of the core functions of care and treatment in forensic mental health services is to enable patients to form, maintain and end satisfying personal relationships, in a manner which is meaningful to the individuals concerned and which ensures the safety and security of both parties'. (Dale, 2001; 127)

This chapter is centrally concerned with the role of nursing staff and the relationship that they have with the men¹⁰⁷. It considers the important security-therapy paradox which is well documented in the literature, and central to both forensic practice and this thesis. It refers to the lack of role clarity and the difficulties in the interplay between patients and staff within secure environments. This includes the necessity to attend to index offence behaviour, in order to manage risks, whilst developing and maintaining non-judgmental and empathetic relationships with the patient. The security-therapy balance¹⁰⁸ was stated to be the most consistently reported dilemma for nurses in secure settings (UKCC and University of Central Lancashire (UCLAN), 1999; 14-34).

Although appearing as binary oppositions, security and therapy can and do co-exist in forensic nursing (Peternelji-Taylor and Johnson, 1996). Nurses working in forensic environments also have a unique working environment; they are viewed by the men *'as being a source of treatment, comfort and advice'*, often over a number of years, and *'at the same time as part of the system that deprives them of their liberty'* (UKCC and UCLAN, 1999; 42). The secure roles of nurses have been reported to lead to scepticism towards staff from patients, and from staff towards patients (Walsh, 2005). Despite this, forensic settings have been described as places of care and compassion (Martin and Street, 2003).

¹⁰⁷ It is designed like the other results chapters following the same format of paradoxes and their main repertoires and arguments, which are then analysed for ideologies, functions and the practice which they legitimate.

¹⁰⁸ Also referred to as the care/custody paradox.

Paradox 6 – Staff are caring and therapeutic - Staff maintain security and are part of the system that detains the men.

Relationships and the Security-Therapy Paradox

Paradox # 6 - Staff are caring and therapeutic– staff maintain security and are part of the system that detains the men

The major paradox of forensic nursing practice is that of being a caring nurse trained to believe in protecting the men's rights, whilst detaining patients and being concerned with security

- Staff would like to form personal relationships with the men – but cannot because of risk
- Staff recognise importance of relationships – whilst giving little of themselves

Repertoires of Security

1. Distance and mistrust in relationships
2. Nurses viewed as prison wardens
3. Governmentality: staff know best

Repertoire #1 – Distance and mistrust in relationships

The staff member is describing how s/he feels that s/he is unable to discuss his/her family with the men. The implication is that this could put them at some type of risk:

“Erm. I would hope that I have a positive influence on the lads as a role model. Erm... again with being a secure environment how much you can give of yourself is limited. For example, I'd like to be able to talk about my family and how I interact with them but in a secure environment with people who have committed sexual offences, them knowing details about your family is often difficult and what you actually give of yourself is difficult

but on the positive side of things I would like to think that my actions on the unit are professional but not so professional that I'm cold to the lads. Erm... and things are kept less formal..." (Staff 1)

The staff member is describing tensions in his/her work within a secure unit; the tensions of being a nurse, caring, comforting and even befriending the men – as the staff and men often work together for long periods of time, so relationships are built. But there is tension between what is seen as the normal role of the nurse for people with a learning disability and his/her role in a secure environment with people who may have broken the law and are more likely to have been convicted for aggressive or sexual offences. This repertoire contains beliefs that the staff would generally share such personal details with patients and assumes that perhaps the staff's family may come to harm through divulging such information. They legitimate more distant therapeutic relationships. Such tensions are acknowledged in the literature¹⁰⁹.

The men feel like they should be trusted, but are not

Here, Matthew is discussing how the men feel that they should be trusted more:

"...I'm not really, I'm not getting trusted. I've lost all the trust that I've had and I've tried to tell them that I can be trusted, but they're saying, "Well, you're up here we can't trust anybody." I mean, like, every 15 minutes or something, they're doing obs [observations, where the staff are required to check where each man is and record it] on everybody. Every 15 minutes. Saying, like, "Person was at that particular in the day room." And then, they're writing little bits about, saying, "Watching TV"... all that's changed is that I've got a member of staff by my side all the time. And it's not nice." (Matthew)

Matthew is describing self-blame for loss of trust, almost justifying the staff for not trusting the men.

This also assumes that the staff are right in not trusting the men and legitimates self-blame.

Men do not trust the staff

This staff member is discussing the way in which the staff are often viewed with suspicion by the men upon admission:

"And the patients knowing us and trusting us that we, you know... The type of patients that we have on here, they're obviously all offenders... So their initial, sort of, reaction is to distrust us. So you have to build that trust with anything that we do for them, we're doing to help them. Because patients are always initially very suspect of us... they view us more like prison wardens when they first come in. Rather than people that's trying help them." (Staff Focus Group)

¹⁰⁹ The literature describes the difficulties of negotiating within specific cultures, especially where there is a lack of traditional barriers. The introduction of therapeutic techniques may leave the nurse more open to manipulation and danger unless boundaries are observed closely (Dale, 2001).

The men's historical experiences of professionals add to their suspicion:

"[I would have to be there] Aye. To see what's going on. Because sometimes if things are jotted down on paper or whatever and you don't know what's going on. I mean, anything could be written down... and it's happened in the past, where I've had, like, letters from the social worker and he's put down things that I've never said in the letter and sent it to the ward. It was like for tribunals reports." (Joseph)

Such repertoires include assumptions that the staff can't be trusted to write their reports on the men, and functions to show that the staff are not trustworthy. It legitimates discounting staff reports.

Similar accounts of staff and patients failing to trust each other are commonly described in the literature (Walsh, 2005). Implicit in such repertoires are ideologies which view the men as dangerous and untrustworthy¹¹⁰. The staff believe that the men may be a threat to their families and this creates tensions for the development of therapeutic relationships and legitimates distance and mistrust (Dale, 2001; Dale *et al*, 1999). The men believe that the staff over-observe them and appear to blame individual nurses when they may not have been involved in that decision at all¹¹¹. The function of such repertoires could be to blame the staff for mistrusting the men, when the men's own behaviour may be considered the cause of the observation levels.

There are differences in the way that the staff and the men view such relationships and duties which may be reconciled only when one understands the perspective of the other. Key to this relationship are rules and procedures which interfere with their development to ensure everyone's safety.

Repertoire #2 – Nurses viewed as Prison Wardens

Detention is required in the MSU, but its purpose is for treatment and not punishment. The men must be treated in safe and secure, yet caring and therapeutic, environments to get the best out of their treatment (Dale and Gardner, 2001; 251-271). Unfortunately the balance between security and therapy is not one that is evidenced in literature and is difficult to find.

¹¹⁰ Similarly the staff are mistrusted by the men, who often come to the service from dysfunctional and abusive relationships which may alter their ability for functional understanding of relationships (Dale, 2001).

¹¹¹ The observation level that the men are held at determines how much supervision is required for each man and is a legal decision in some cases, or a clinical decision made by the multi-disciplinary team, not an issue for individual staff.

Nurses lock the men up

Nurses in these environments may be required to carry out duties such as seclusion:

'Seclusion is the supervised confinement of a patient alone in a designated room...'
(**Seclusion Policy, 3.1 – 3.2.**)

Observation and restricting the men's movement are part of the staffs' duty:

"[the nurses...] Observe... I've tried to tell them that I can be trusted... "I want to go off to my room" on a weekend. And just have free time. Because they're saying if you do that then a member of staff has to be observing you having your free time. So they can't really afford to make the staff go out of the day room, up onto the landing to watch the lads have their free time... You can't get out of the club neither, because they're short staffed... Outside - it's a different kettle of fish. Because I had full ground parole before I came up here and I began to work myself [misbehave]. Going to the club myself, going for a walk myself, going to the garage for myself... I would never abuse it... And now I still haven't abused it because I'm just what I am and who I am when I go out." (Matthew)

Some nurses lean towards security

The staff have many powers but are bound to engage these powers in a humane and therapeutic way. The staff report the personal behaviour of the men to the management:

'If it is known or suspected that such contact has occurred [sexual], staff will respond according to the nature, severity of the situation and its contextual factors. In all cases, a Risk Assessment will be carried out immediately after any more pressing issues have been resolved, and the incident will be reported to the [unit] Management of the respective patients.' (Sexual Relationship policy, 11)

This power is a great responsibility for the nurses and one which depends upon the ethical stance of the nurses and their beliefs about the people whom they care for¹¹²:

"...but I think there's certainly a stereotype... I would say that the longer you've been in a forensic setting, the more you probably lean towards security over choice. (pause)... Yes, there's differences between members of staff but I wouldn't necessarily group them into... obviously from where they come from their beliefs... as a member of society, somebody that comes into the hospital then starts working then obviously they already have those beliefs and influences so people are different in that sense... There are differences between individuals and like I say along the therapy security continuum erm... what makes those individuals somewhere on the scale like I say there's two things for me; time within the setting erm... I'm trying to think does age matter? In some cases, yes. (long pause)... That's it, I think." (Staff 1)

Staff report the behaviour of the men

Such repertoires carry beliefs that it is the nurses' duty to secure and report the men, that nurses are uncaring and mistrusting and do not adhere to the security-therapy balance. They legitimate any

¹¹² Please see: Morrison, 1990; Walsh, 1998; Martin and Street, 2003; Dale and Gardner, 2001(251-271)

differences in the staff's approach to security-therapy balance. However, this should be about treatment and not about the age, experience and education of the staff member, as this may lead to the men being treated inconsistently and, perhaps, unfairly.

Repertoire #3 – Governmentality: staff know best

This repertoire is important and occurs frequently in the data. It justifies many practices within the analysis. The staff claimed to be choosing¹¹³ which men participated in the LS because of certain criteria believed to be important for its success, including understanding and skill - but actually chose men whose behaviour was more suitable rather than relying upon the chosen criteria.

Staff may judge others

All participants¹¹⁴ agreed with the criteria for choosing the men; believing that understanding, consent, behaviour, possible disruptiveness and commitment were important to think about when choosing which men should be asked to participate:

"I think there's certain ones who would have been very disruptive. And it would have had a negative effect on the rest of the group. Those who have difficulty tolerating their peers, let alone interacting with them sensible in a research project." (Staff Session)

This staff member gave justifications for excluding some of the men on the MSU because of behaviour and the effect they may have had on others in the group. These justifications for exclusion from the LS are the same reasons why, traditionally, anyone with a learning disability has been excluded from research and treatment decisions and normal social opportunities¹¹⁵. It has assumptions of deficit and 'we know best' - the staff can judge and such ideas legitimate researchers and staff taking control over the research recruitment process:

Participant

"...he writes reams and reams and paper, daily, about [area name] as it was then. But he doesn't, sort of... I mean, we've had English lessons and various sessions and there's just, there's no-one been successful in getting on to anything else around this. The only thing that he's sure of is that he enjoyed the sessions and the tea was lovely."

Interviewer

"There's a start." (Staff focus group)

¹¹³ The LS began with a staff session in which all participants decided that the staff would actively recruit men from the area in which they worked.

¹¹⁴ Excepting the men, as they were not involved at this stage.

¹¹⁵ Education, employment or relationships, for example.

Contrastingly, they appeared to choose men of whom they had low expectations of understanding¹¹⁶. So the staff may, in fact, have been more concerned with behaviour and security rather than ability. Even though the LS was a collaborative piece of research, we still justified asking the staff to choose the men, rather than asking all of the men to volunteer – therefore those without a learning disability maintained control of the research.

Staff are experts

Running throughout the medical model and policy is the notion of the staff as experts:

'The Nurse in Charge of the seclusion facilities will manage the period of seclusion'
(Seclusion Policy, 5.1.8)

This applies even in issues of personal relationships between the men:

'In the interests of maintaining necessary security, whilst providing for a therapeutic environment in which to promote positive personal relationships, and in order to enable care and professional staff to reasonably monitor and manage relationships between patients, particularly where the issue of consent and safety is concerned, physical contact of a sexual nature is not permitted between detained patients whilst they are on Trust premises or under the direct supervision of Trust employees'. (Sexual Relationships policy, 10)

The staff member below is discussing how they may make decisions for reasons of security and safety:

Staff

"For instance, out of the six lads on here sexual offences has been part of their forensic background. If yourself, for instance, was taking part in a group setting there could quite easily be inappropriate sexual remarks, inappropriate touching at which point that would be my responsibility to intervene and therefore the power imbalance... if I was to be restricting them in any way, there's a power imbalance straight away. I would say that would come up at some point."

Interviewer

"Are there any ways they could be overcome?"

Staff

"(Long pause) Yeah. Things like that, there's not much you can do, that kind of supersedes... problem from my point of view would be the safety of yourself and other clients supersedes the results of research. Erm... and empowering them and feeling research is important... to me that (security) is more important." (Staff 1)

Again, there are assumptions of expertise and competence in the staffs' ability to judge the men and justify and legitimate control over the men's opportunities and behaviour. The repertoires of security include mistrust between the men and the staff, where the men are viewed as dangerous and the staff

¹¹⁶ For example, the staff included the man referred to, who they knew lacked understanding, commitment, concentration and would only enjoy the tea and biscuits.

are viewed as prison wardens. The staff are justified as experts able to judge and control the behaviour of the men who cannot control themselves.

Repertoires of Therapeutic Nursing

Some of the personal characteristics described in these results reflect those in the literature on 'good nurses'. Studies show that these characteristics are related to ethical practice and important in nursing (Bjorkstrom *et al*, 2006; Scott, 2006). Characteristics of the "Good Nurse" should involve a knowledge base; a certain level of understanding and skill; a good education; and a range of personal attitudes, moral or ethical traits: e.g., doing good for others; being competent and skilled; having professional courage and pride; and seeking professional development¹¹⁷.

Smith and Godfrey (2002) found that almost a third of the answers to who is the good nurse were categorised as personal characteristics including being pleasant; having integrity; being committed; having understanding; being conscientious; showing common sense and kindness; and being genuine and honest¹¹⁸. Patients need to develop a trusting relationship with the nurse and it seems necessary for nurses to demonstrate 'good' nursing characteristics to enable them to use their skills, knowledge and experience to become competent nurses (Lofmark, 2006). Of particular note to Reed *et al* (2007) is how much the forensic staff loved their job and believed that commitment was a crucial characteristic as well as:

- empathy
- compassion
- a certain 'warmness'
- non-judgmental attitude
- staff being mindful of the service user's complex history to assess risks
- risk being managed in a humane and caring way

¹¹⁷ Please see: Turnbull & Paterson, 1999; 99; Smith & Godfrey, 2002; Bjorkstrom *et al*, 2006; Lofmark, 2006

¹¹⁸ Please see: Wilson & Startup, 1991; Smith & Godfrey, 2002; Scott, 2006;.

Repertoires of Therapeutic Nursing

The repertoires of therapy include 'good nurse' characteristics and ideas of individualised care built upon sound therapeutic relationships with the men:

1. **Nursing values and skills**
2. **Help and treatment**
3. **Therapeutic relationship**
4. **Good staff relationships**
5. **Humour**
6. **Staff take pleasure in the men's achievement**
7. **Men and staff enjoy each others company**

Repertoire #1 - Nursing values and skills

Non-judgmental

"...And you'll treat them the same, no matter what." (Luke)

"...actually because we are working in a medium secure unit you go past the reason why they're here and you get to look at the person and why possibly they've done the things that they've done or whatever or the reasons why they've offended but you go past the offence and you get to know the person. You get to help the person and not all the time but we don't have any real close contacts with family but you get an insight into to how they've actually come to this stage." (Staff 4)

Non-judgmental repertoires contain beliefs that there are reasons why the men offend; it is the men's background that leads the men to offend, not themselves or their learning disability, so the staff should not judge the men. Here there is a separation of crime and criminal and the belief that the men should be treated as individuals. These beliefs legitimate the humane treatment of the men, placing value on good relationships with staff and therapeutic practice rather than being security focussed.

Therapy

"We do our best that we can to get that balance right." (Staff 1)

Enjoyment for staff

"It is apparent that the staff and men have very warm relationships. The staff appear to enjoy the company of the men and their work. The men appear to trust and admire the staff... There is often humorous banter and telling in-jokes." (Researcher field notes)

These repertoires have ideologies of underlying nursing values, belief in the therapeutic relationship and show the men as valued, despite their forensic background or index offence. They show assumptions that the staff can balance security and therapy and can judge when it is balanced. They legitimate the view that nursing staff have good underlying nursing values and that they value the men and their relationship, thus making them trustworthy practitioners.

Repertoire #2 - Help and treatment

"Well they try and help you, like, going to get you things from the shop and stuff like that, from outside... Get you like games and stuff like that. Because if you can't get out they'll try and help you as best way they can. To try and get you one... They'll try and, if you, say, like if one of your relatives have died they'll try and talk to you and that. Try and persuade you. Try and help you." (Joseph)

An important aspect for the staff is building relationships with the men, in order to help them:

"They look after us... Help us to cope in our environment that we otherwise wouldn't be able to cope in ourselves... That have a chat to us and they tell us what's what. And how we can do stuff. And they show us as well." (John)

Such repertoires show the staff in a caring and comforting role and that the men admire the staff. They display assumptions that the men require help and advice and that the nurses can help and advise well. They legitimate a view of a caring role within a secure setting based upon unequal power.

Repertoire #3 - Therapeutic relationship

The staff would like to form friendships with the men but feel that they are not really supposed to because of the men's forensic background:

"Well, you get to form friendships with them[the men] I mean we're not really supposed to erm... because it's against staff and patients in this area but you do, you form friendships, not attachments but..." (Staff 4)

Repertoires such as this show implicit beliefs about the men's dangerousness in that the staff should not get too close to the men. Thus, there are still assumptions of mistrust. However, it may also be to do with staff culture, their belief system and/or policy that legitimate distancing relationships between staff and the men.

In observing the relationships between the staff and the men there appeared to be a very warm and encouraging relationship:

"After the session [the staff] were, like, amazing... Because they gave you little clues and little things that you didn't think of before... So in the actual discussion [in the workshops] they didn't really play much of a part, but afterwards they were just phenomenal." (Luke)

The staff reported certain changes to the relationship with the men because of working together on the LS:

"Well I think it was nice to mix [with the men] and to get off the ward..." (Staff 6)

These repertoires demonstrate good, warm relationships between the staff and the men and legitimate the current practices. How much the relationships are on the staffs' terms is unknown.

Friendly

"They look after our welfare needs. Help us with any problems we might have. Give us a friendly person to talk to." (Luke)

Staff help raise self esteem

The staff often have a difficult role in trying to help the men to raise their self esteem, when they have double or triple stigma attached to them and have been through a criminal justice system that they do not understand, and then to a medium secure unit removed from their friends and family, often by many miles:

"Raising self esteem on this particular unit is a difficult thing to do. It's not always easy... Because of the access to integrate the men into the community is not always easy because of the restriction of the risk they pose to others." (Staff 4)

Such repertoires demonstrate how difficult it may be for the staff to help to raise the men's self esteem, as community links are an important part of it. They carry assumptions of risks that the men pose whilst on visits and to visitors. How much the staff may help the men to empower themselves is often restricted by the section the men are detained under:

"...I think Mark was very apprehensive at the start - and very quiet. But he just needed pulling out... but that's Mark. He needs to be pulled into part of it and made to be feel a part and I think that worked really well for him. He got loads out of it. Especially to get Mark to go and stand up in front of strange people members of the public, people who basically would look after Mark, and do a talk, was amazing. I couldn't do it because I don't like talking - hate talking here, by the way [in the interview] - but I couldn't have done that - Standing talking to the public. Him and Luke, the two of them. In fact, when [staff name - not involved in LS but escorting the men to the conference], who came on escort with us, he took the mick out of [teased] us afterwards and says "You want to take a lesson [from] Mark and Luke..", which was right. So that was good." (Staff 4)

Such repertoires show how the staff admire the men, unearth beliefs that staff can help to raise self-esteem in the men and function to show that the staff care. However, it is the men's own achievements that actually raise self-esteem but the staff who take credit for it are viewed as doing a good job.

Staff empower the men

"...They [the staff] learn [teach] us everything they can until we can cope, so when we move on we're able to look after ourselves and do things for ourselves. Plus, the side that you don't realise that they do is they actually do try and encourage you. If you can't do something they don't just sit there and waste their time. They actually try and get you to do it and try and get you to want to learn yourself. And prove to yourself that you can do what you know you can." (Luke)

Interviewer

"What if they say something [in the workshops] and you disagree with them, how might we sort that one out?"

Staff

"I think that'll be fine. That'd be no problem, it's just their opinion but we'll probably say things they don't agree with." (Staff 7)

The repertoires here demonstrate beliefs in the staffs' role as helping the men to help themselves, rather than the men having a passive role¹¹⁹. Here the men can and do disagree with staff and this was apparent throughout the workshops. Such repertoires legitimate the staff feeling that they do empower the men and enable the men to speak out:

"...if the clients feel empowered by being involved in it and they see me as being involved perhaps that'll enhance my therapeutic relationship with the clients, as me as someone who as helped to empower them... Being able to spend time with the lads - form greater relationships because of them... Typically you can be prescriptive as opposed to facilitating. There was definitely a "working with" feel to the work that we did - as opposed to the staff were running a session that they had to participate in - kind of a feel." (Staff 4)

Empathy

"So I think the big things here is getting patient to trust us. And as [staff name] says, to be able to communicate with them on whatever level. You know, I think we've always got it foremost in our minds that each one of them are individuals and have individual needs and individual levels of understanding." (Staff Focus Group)

Building Trust

"...they're all there to provide a care for who's in their trust. You see, if you're a nurse or a doctor or a shrink or whatever, you're entrusted with the responsibility for the people that you look after..." (Luke)

¹¹⁹ The men's passive role is apparent in other parts of the data.

Helping the men is seen as the major part of the staffs' role, and they do this through treating them as individuals and building effective therapeutic relationships with them – of course, this assumes that the men need help and the staff can give it. They have beliefs in individualised nursing care, yet they use the grading system. They also talk of getting the patient to trust them - this assumes that the staff are trustworthy. The importance of raising the men's self esteem and empowering the men is stated; it is viewed as a significant part of the staffs' role and, as such, the staff take some credit for the men's achievements. Such repertoires legitimate current practice and function to show the staff as caring and enabling the men. They normalise the men trusting the staff and the ability of the men to speak out.

Repertoire #4 - Good staff relationships

The staff and the men expressed good working relationships within the MSU. This was an important aspect, as the relationships developed between the men and staff are important, but also the relationships between the staff are significant:

"...I say there's a good staff team, there's a good management team on here. I think you can go to them if you feel... not upset but unhappy with anything you know. They're very willing to listen, you know, and they're not like 'managers' or 'qualified', everybody is a team. There's no [hierarchy]... I would say although you respect your... people above you but erm... they do help you out." (Staff 3)

These repertoires function to show a casual and close working relationship between the staff and deny the hierarchy which is apparent in forensic nursing. The ideologies implicit within such repertoires function to show that the staff trust and care, not just for the men; but for each other too.

Repertoire #5 - Humour

It was obvious from being part of the LS and spending time with the participants that, despite the forensic nature of the setting, the relationships were important and relaxed, with humour being a frequent occurrence:

"To be honest... I used to be on another flat [unit on MSU] and erm... I like this flat. I think I have... with it being an older place I'm quite one of the youngest member of staff and I'm quite a bubbly character and I think sometimes when I'm bubbly I have a laugh and a big sing song and you get on better with them because they're laughing with you. When they're laughing with you they're not getting themselves into bother." (Staff 3)

Luckily the staff don't always take themselves too seriously:

"You've got to listen to this one... one of our [staff] took the van to [local] hospital and he parked it on the big H because he thought it was H for hospital transport and not H for helicopter." (Staff session)

Below, the staff are discussing Paul, who appeared to have a lower level of understanding than the rest of the men in the LS. However he did pick up on the consent issues described and generalise them from research to consent to treatment – here he jokes about refusing his prescribed medication:

"Whether he was learning his level of understanding of what he was going on about, I don't know. But he knew what they were talking about. As in, "We were talking about consent. Now I said I don't want my tablets, then I'm not consenting." And like we would be, "Hold on Paul". And it was things like that. But he would come up with little things, so he did take some things in. But I don't know about the whole... Yeah. Humour. He's very humorous is Paul. He brought humour to the group." (Staff 4)

"I get on too well [with staff]... Because I sort of play practical jokes on them and call them old men and say that they've got grey hair and I come up with nicknames for them all and I insult them and everything." (Luke)

"You can go after them [tease the staff]. A good bit of crack and they have to respond. Like, they're here for support if you need it. Somebody to talk to if you've got problems." (Mark)

They also used humour to deal with the, sometimes terrible, offences that the men commit:

Respondent 3

"I know we would all like to bring the ones [the men] who we think will come every week and at least participate and get something out of it. And give you something back as well. You know.. We want, at least, a patient who it'll work [for], sort of thing. You know, and they will continue for the 6 weeks and not have to be removed and..."

Respondent 1

"Or fall asleep at the table or..."

Respondent 3

"Or start doing other things, you know?"

Respondent 1

"Do you know what I mean? Or pinch your purse or..."

Respondent 3

"Bottom." (Staff session)

Obviously the men were not detained for pinching someone's bottom, but it may be reference to theft and sexual offences¹²⁰, and function to deflect the seriousness of the offences through humour.

Humour is viewed as important; it helps with the men's behaviour, staff use it to deal with the serious nature of the men's offences and it functions to cement relationships. The humorous discourse

¹²⁰ Offences for which men with a learning disability are commonly held.

demonstrates a warm and balanced relationship between the staff and the staff and the men – but it isn't a power balanced relationship.

These repertoires hold assumptions that humour is not used for power, but for good relationships and fun. Staff allow the men to tease and joke to ensure good behaviour and relationships. This may mean that humour is used as a behavioural technique through beliefs that the staff's personality matters as the men behave better when there is fun. It also suggests that the staff understand the men. These repertoires legitimate humour and teasing among the men and staff which is not always productive or fun as Joseph described earlier.

In the same way, the men might hold power here as they allow the staff to use humour – if they do not or could not use humour, then the staff would not be able to use it as to do so may mean they would be viewed as teasing or being patronising.

Repertoire #6 – Staff take pleasure in the men's achievement

The following extract expresses many of the feelings that the staff had regarding the LS. All of the staff expressed pleasure and pride at seeing the men achieve, surpass their expectations and gain in self esteem:

"...I like anything to do with patients, I love. Because that's what I've done for the past dot years - 18, God! But... so, anything they're doing and getting them to do something has been good for me... if Mark wanted something finding out for him... twenty minutes here, twenty minutes there was... I got more out of that because he was actually - you could see he was taking it in. And... When they did the presentations [at a conference], that's it! When they did the presentations, just to see Mark present the way he did..."
(Staff 6)

Such repertoires demonstrate high regard coupled with low expectations of the men, yet legitimate the staff as good nurses and their practice as sound and not task oriented. They carry ideologies of the staff enjoying the men's achievement.

Repertoire #7 – Men and staff enjoy each other's company

"You can go after them [tease the staff]. A good bit of crack and they have to respond. Like, they're here for support if you need it. Somebody to talk to if you've got problems."
(Mark)

"Well, they try to look after you in as best a way as possible I think... Well if you need to talk to them they're there to listen and that. If you've got a problem or something or if they can't help you, they'll pass it on somebody else higher up or something. Which is okay." (Joseph)

"They look after our welfare needs. Help us with any problems we might have. Give us a friendly person to talk to. And give us advice. They learn us everything they can until we can cope, so when we move on we're able to look after ourselves and do things for ourselves. Plus, the side that you don't realise that they do is they actually do try and encourage you. If you can't do something they don't just sit there and waste their time. They actually try and get you to do it and try and get you to want to learn yourself. And prove to yourself that you can do what you know you can." (Luke)

The staff also acknowledged their ability to care about the men's welfare and wanting to help the men to improve, as well as receiving pleasure from the men's achievement:

"... that probably summed the whole project up for me. Because he stood up there and did something, like I said before, [that] I couldn't do. And I would say I got that out of it more because it... there was an end product. And the best thing about being involved? Again, just the patient contact... I mean, we'd had patient contact every day; we were looking after them. This was completely different. It was something different for them to go away and do. You could see they were doing it. Especially my two [men]. I don't know about the other ones, but my two were involved from the start. Wanted to be involved. And giving them something different and being able to like assist them in doing it - that was probably the best thing for me. And again, the end product. Seeing Mark up and Luke up on the stage..." (Staff 6)

"I got a lot of satisfaction working with the lads... Because they were really interested in it [the study]. And they wanted to learn about research. So it was a good thing, I think. They really looked forward to the sessions and everything... Why was it so rewarding to me? Because they were doing something that they enjoyed... the involvement of the clients, that would be the most positive thing for me personally." (Staff 3)

It remains clear that the staff still value the quality time spent with the men, rather than the security and task oriented part of their role:

"Well I think it's nicer working [on the LS], rather than when you're in the confines of the ward and you're doing about 20 different tasks at once - answering phones etc. You can only sometimes spare, you know, a two minute answer to one patient, a two minute answer to the other. It's nice when you've got a little bit more quality time to spend with, say, one patient. I felt, you know, you get a lot more rapport and things. That's what I enjoyed." (Staff 7.)

"It was nice to come with Paul... Because it's not very often that you're one to one with people." (Staff 6)

Warm relationships between the staff and the men are evident within the data. The use of the term 'lads' suggests power relationships as the men are referred to as younger than the staff. This may be a hint of a more casual relationship than is apparent; i.e. one which is not ruled by legislation, policy and duty. It is also reminiscent of the term 'girls' referred to as the 'infantisation' of the Broadmoor

culture which was linked to patronage and a failure to recognise the needs of the adult women in their care (Special Hospital Services Authority, 1993, cited Dale, 2001). The men also refer to each other as 'the lads'.

The therapeutic repertoires show the nurses as experts helping inadequate men. They show the staff as generally trustworthy, with a genuine concern for the men and their welfare. Considering the security measures that the men and staff have to deal with on a daily basis, such repertoires appear amazing to find, but were numerous in the data. The men and the staff appear to have found a way through the security measures and tensions that they create, to develop a mutually caring therapeutic relationship. However, the staff have dual roles which appear incompatible and mean that they are viewed in oppositional ways. Despite such oppositional views regarding the need for security and the men's rights and restrictions, the staff and the men were witnessed to share close, trusting relationships. The repertoires of the staff in their binary oppositions follow in figure 3.

Summary

This chapter is centrally concerned with the relationships between the men and the staff and forensic practice. The security-therapy paradox is explored and shows repertoires of mistrust and suspicion as the staff are viewed as prison wardens and not as nurses. Such repertoires have underlying ideologies of mistrust and legitimate the staff being viewed negatively. However, there are also repertoires which function to show the staff as caring, encouraging practitioners who share warm and productive relationships with the men. Such repertoires have underlying ideologies of care, compassion, empathy and a non-judgmental approach and are present in the literature as 'good' nursing qualities. Humour and fun were again viewed as important aspects of the relationship and part of the practice in such settings.

The final chapter concludes the thesis by examining the major findings and their implications for the men, forensic practice and nurse education.

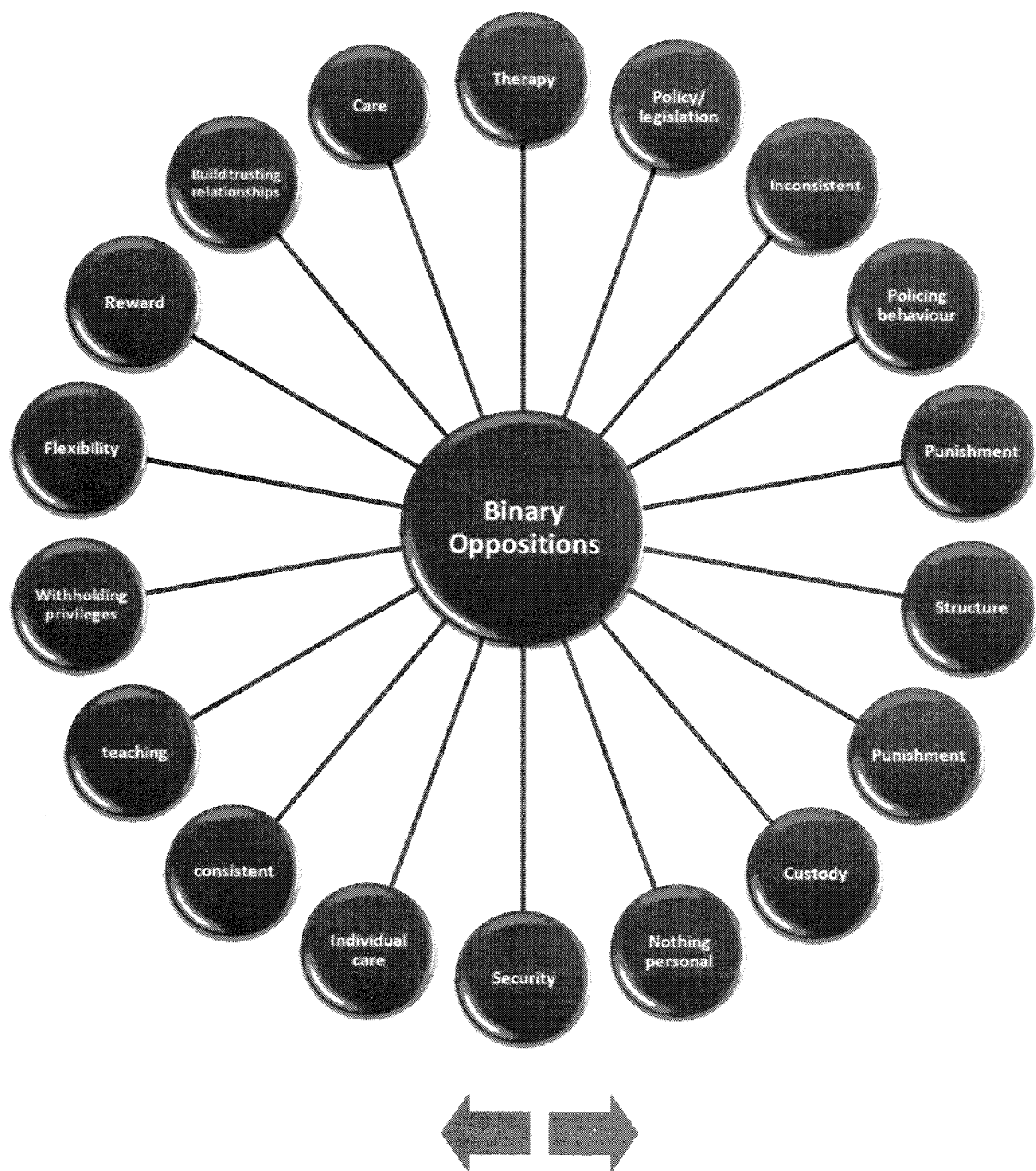


Figure 3: The way that Nursing Practice is viewed by the participants

Chapter 9 - Ideology, Paradox and Truth: Implications

'Research and development are not always seen as inherent parts of health care practice and yet together they form an issue that is central to the ability of a profession to define its own knowledge base'. (Clarke and Procter, 1999; 975)

This is particularly important in the relatively new arena of forensic nursing that does not yet have such a robust evidence base (Clifton and Harvey, 2001). This thesis augments the evidence base for nursing, adding to the essential theoretical underpinning (Ellis and Lee, 2005). This chapter begins with a brief summary of my main arguments, leading to suggestions of ways in which this thesis may impact upon current views and the men, practice, education and research.

To aid the reader, the general research questions are:

- ***What are the discourses related to learning disability and forensic practice?***
- ***What are the positive discourses?***
- ***What ideologies underpin and justify forensic practice?***
- ***What does this mean for the men, future practice and nurse education?***

The first three questions have been answered in the three results chapters, and along with the fourth and final question they will also be attended to throughout this chapter.

Forensic practice has been shown to be a difficult area for nurses to work in and for people to live in. There are aspects of detention which appear questionable and which appear to have little justification. The men are deprived not only of their liberty, but also of their choice, privacy and dignity. In this thesis I question the justifications for restrictions of rights and lack of choice. I expose inconsistencies in ideologies underpinning practice; questioning knowledge previously taken for granted. The men have been given a voice and an opportunity for intellectual discourse and achievement. They have been enabled to discuss the positives as well as negatives in detainment and their opinions will be heard by the profession and giving a fresh view of their practice from the men's perspective, possibly leading to changes in forensic practice.

There are certain ideologies which underpin and justify forensic practice: discourses of difference; deficit; vulnerability; dangerousness; illness; governmentality; and repertoires of restrictions and security. These, in turn, are questioned by paradoxical discourses such as: advantages of having a learning disability; vulnerability; the social construction of learning disabilities; discourses of sameness; negative aspects of detainment/security; therapeutic repertoires of staff; and repertoires of rights.

Discourse and People with a learning disability

Central to this thesis are ideas of difference and the unearthing of different truths about learning disabilities; ones I have always held of the advantages of having a learning disability and the advantages to those who live and work with people who have a learning disability. This was made more difficult, firstly, as my truths were not dominant in discourse - although they were confirmed in the results and in the self-advocacy literature. Secondly, the authors of the disability literature are commonly disabled themselves, which appears to justify their opinions – it seems quite a different matter with literature on learning disabilities where a very small group of self-advocates were the only ones to be speaking out on others' behalf (Docherty *et al* 2005). Therefore, my opinions, it can be argued, may hold less weight here.

However, I argue that people with a learning disability are not a homogeneous group, so they may not be justified in speaking on others' behalf. Furthermore, the few self-advocates did not seem to represent all of the ideas that I understood about learning disabilities. And as it is commonly academics who reported the views of self-advocates they may also have their own agendas – as do I. For these reasons, I feel secure in my views as it was the men themselves who gave me permission to analyse and report their views – their consent and trust justifies my account. Of course, the findings of my analysis and the interpretations are skewed by my world view, belief system and agendas which were set out in the preface so that they were transparent for the reader – and contained in this chapter are what I believe to be the most important lessons learned through analysing the data using critical discourse analysis which I reported faithfully.

Please see Figure 4 below which offers a diagrammatic overview of the study showing possible implications and follow up studies leading to organisational, clinical and educational change.

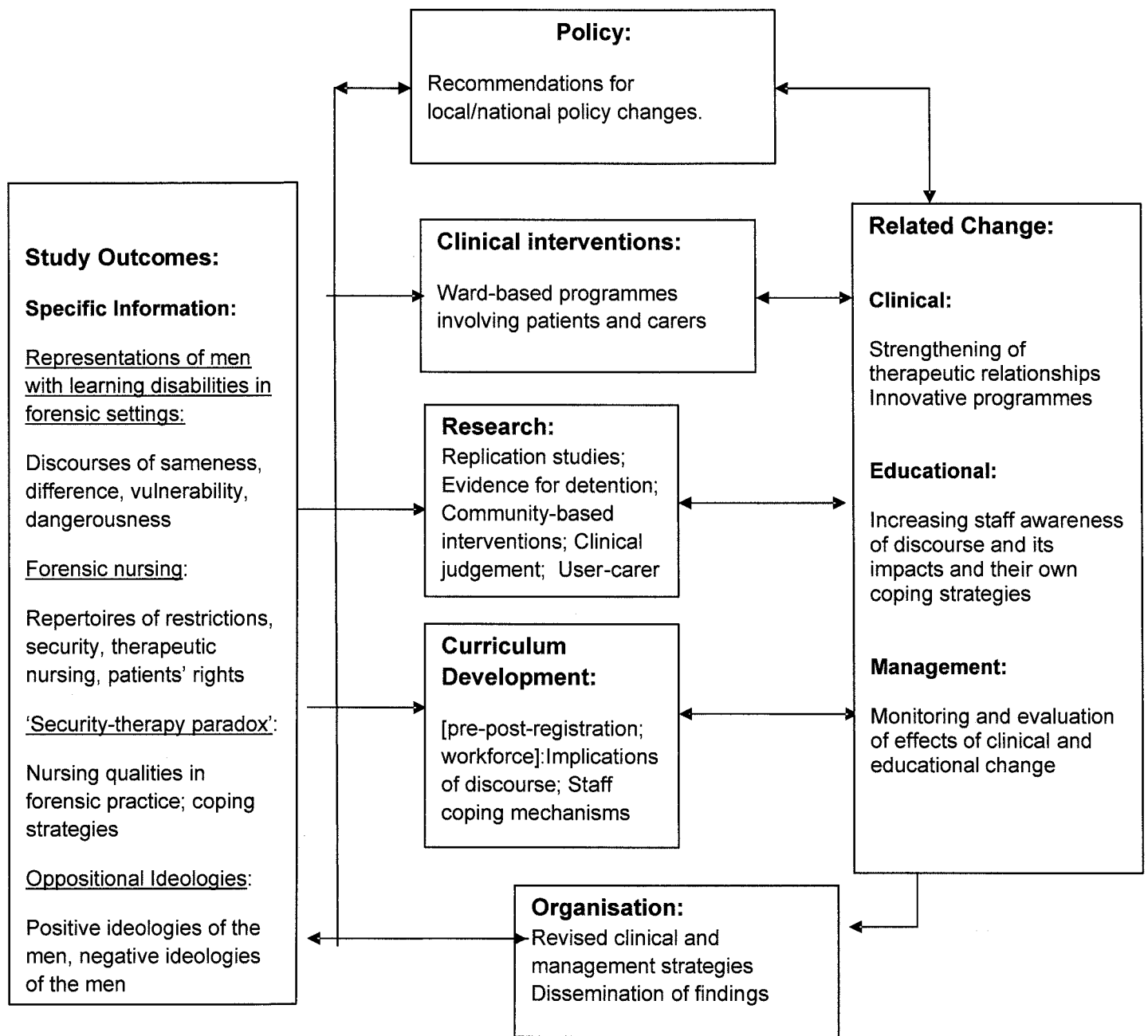


Figure 4: Diagrammatic overview showing possible follow-up of study outcomes, leading to organisational, clinical and educational change

Macro-models differ quite fundamentally in their view of difference; SRV, the medical and personal tragedy models view difference as negative and seek to normalise and control such a difference. The social and affirmation models do not view difference as negative and the normalisation of disabled people is not sought, instead they advocate that society changes its view of difference and disability. The way that difference is envisioned is fundamental to how disability is viewed. Hence if people with a learning disability are perceived as different, then this enables them to be treated in a different way, especially if this difference is viewed as negative. The discourses of difference show the men to have deficits in ability and behaviour, and enhance the status of staff who care for them and control them (Goodley, 1998). The data showed that the men are viewed paradoxically as different and as the same.

Arguments for sameness challenge the dominant views that the men are very different from the rest of society and function to lessen the impact of disablement and prejudice, or the accusation of it. It appears paradoxical that the men are reportedly both different and as the same as others – this also occurs in policy and continues throughout most of the text. Discourses of difference allow specialist services, but describing people as the same too is ideologically incompatible - it appears the politically correct thing to do. Discourses including both enable the speaker to describe difference, and justify differential treatment, whilst avoiding blame through rhetoric.

Importantly, discourses affect not only how we articulate and understand but also create the world around us. We all have a hand in the creation and maintenance of discourse. For people with a learning disability this is perhaps less so, as in Foucauldian terms they have little influence in the creation and use of power. Power is created through knowledge according to Foucault, and we are all disciplined through the creation and maintenance of this knowledge. The powerful show us how to behave and live by creating norms through truths we all know. For example, we all 'know' that the mad are dangerous and that it must be a tragedy to have a disability; these truths are so deeply ingrained in the *psyche* of society that it is difficult to change minds even when faced with evidence. Existence outside of these norms has dire consequences; therefore we generally strive to stay within them. People with a learning disability do not fit into such norms - and the consequences of this are

to be viewed and treated as different. The men have thrice digressed from this norm; they not only have a learning disability but have been diagnosed as having a mental health issue and have also offended. The consequences are to be detained under the Mental Health Act in the MSU, often for many years.

Foucault tells us that truths may be challenged successfully through challenging the dominant discourses; and this is a very postmodern idea. The discourses about people with a learning disability are, indeed, important and have changed historically. In the education era, they were trained. In the era of hospital care they were institutionalised; normalisation sent them back into our communities, but the price was to be normalised. The disability movements showed a new way of conceptualising impairment, and that the impairment was not the issue, but the way in which impaired people are disabled by society. However, most of these ideas were not transferred to people with a learning disability who were still viewed very much as outside the disability movement, and viewed as different even from other disabled groups (Docherty *et al*, 2005). Nevertheless, the affirmation model managed a positive view of learning disabilities which urges that disabled people's experiences be re-evaluated as positive, without normalising them.

Implications for the men

The patient is at the centre of nursing practice and as this thesis attends to issues which underpin it this may impact upon all aspects of patient care; assessment, therapeutics, education of families, research and, ultimately, what affects patient outcomes (Zuzelo, 2003). It may also have potential influence on the experiences of the men as this thesis questions their current low value, expectations and the paradoxically high demands placed upon them.

We still underestimate people with a learning disability; the positives that are unearthed here¹²¹ may go some way to dispel the myths and increase expectations, to thus opening up opportunities for the men.

¹²¹ Please see appendix 14.

Affirmative arguments

The men were represented as positive and such affirmative repertoires¹²² exist in all of the results chapters and contain ideologies of a group identity that assumes that people with a learning disability are a homogeneous group - what is true for the men is true for others with learning disability. The men do not view their impairment as disabling, but blame the stigma attached to it. Such ideas legitimise society's blame. Difference here is positive and legitimates the involvement of people with a learning disability in research and related activity for other reasons than expertise in their own impairment. Being viewed as important in academic work is not a commonly reported experience for people with a learning disability. Such positive ideas of learning disabilities are apparent in macro-models, such as the social and affirmative models and function to enable a positive self and group image, elevate the men's status, question discourses of deficit and challenge views that people with a learning disability are not valuable to academia and society.

Implications for Practice

Organisational policy

The organisational sphere which my research may potentially affect includes addressing processes, strategies, policies, initiatives and programs through questioning philosophies and ideologies which underpin them. It may inform care initiatives and system-level policies through utilising valid and reliable social science methods which question the beliefs and assumptions upon which they are based (Zuzelo, 2003).

Forensic Practice: Repertoires of security and therapy

This thesis explored the ideologies behind what we do as nurses and the value of those we serve. Therefore, it may aid in the development of critical practice. According to Barnett (1997; 102-116) critical practice operates across three domains: critical analysis, critical action and critical reflexivity, all of which are apparent in this thesis:

¹²² Please see appendix 14.

1. Critical analysis evaluates knowledge, theories, practice and policy, recognises multiple perspectives and different levels of analysis and features ongoing enquiry
2. Critical action includes a sound skill base used with awareness of context, operating to challenge structural disadvantage and work with difference towards empowerment – this is important here
3. Critical reflexivity involves an engaged self, negotiated understanding and interventions, and the questioning of personal assumptions and values. (Barnett; 1997; 105).

The next section will examine how my thesis may influence the patient, carer, practitioner and organisational spheres across all three domains of forensic practice. Forensic nursing appears to be heavily influenced by the medical and tragedy models of disability as the majority of discourses were quite negative, emphasising the men's deficits, dangerousness and the governmentality of the staff. In contrast, the staff were exposed as understanding, caring and being non-judgmental. Policy was also shown to view the men as different and ill and used authoritative corroboration to ensure that security and the power of the staff were high on the agenda. As a nurse, I am aware of the paucity of research which exposes the positive attributes of forensic nursing staff and the relationships that they have with the people they care for; this thesis exposes such positive discourses. Please see Figure 6 for a table of implications for the study.

Discourses of Detainment

Foucauldian ideas of power, discipline and normalisation come into play here, as there is justification for security, policing behaviour and dictating rights and choice. Security is peddled as important above all other issues because of the risks the men pose and security is deemed necessary for the protection of the men and of society; to detain safely, security is required.

Positive aspects of detainment

Discourses of dangerousness not only refer to the men as criminal but also include learning disabilities as being synonymous with dangerousness and provide justification for prejudice against people with a learning disability. This is at odds with a common discourse which equates learning disabilities with vulnerability and of the need for protection and control. Such repertoires lead to over-

protection and pity and are similar to the personal tragedy models. They assume inability in the men, carry ideologies of the staff being able to protect the men and staff knowing best, and legitimate control by the staff and restrictions placed upon the men.

Discourses of prolonged treatment/detainment and restriction of rights are justified as the men receive treatment and opportunities to achieve safe behaviour. They promote staff as specialists, defend their governmentality and show that they have authoritative corroboration through concepts of duty, policy and the law to justify the restrictions of even the most private of functions of the men. Often it is stated that it is for the men's own good that they are detained and restricted as their behaviour needs to change for them to be able to move down through security levels and be released safely. It is stated, after all, that it is the men's own fault that they are held as they are dangerous criminals that can be treated differently from other people with a learning disability and other criminals. Such repertoires question positive aspects of having a learning disability and the social model of health and criminology.

Negative discourses of detainment

There were repertoires concerning the negative aspects of detainment which justified the view that the men really should not be detained; they were not receiving treatment, they were just being held. Detainment is viewed as detrimental as they are held far away from family and friends, with dangerous and unkind patients and even (on one occasion in the data) unprofessional staff. Furthermore, policy states that people with a learning disability should not be living in NHS premises. The fact that they are detained is merely semantics - they still are resident for many years in the grounds of a long-stay hospital. Negative detainment ideas question its necessity and that the men are being treated by expert staff. Thus, this challenges that the way they are managed is for their own good.

Repertoires of vulnerability

There are repertoires which function to deny the justification of detainment because of dangerousness, as the men are also viewed as passive patients who lack understanding and ability. Their choices and rights are severely restricted in the MSU, they are constantly observed and this is

perceived as being defensible through the men's poor behaviour, policy and legislation. The grading system judges the men on their performance and enables restrictions and privileges to be given to the men. Their behaviour is observed, reported and judged by the staff - who create and maintain ideas of correct behaviour and have control over the entire process – and this is warranted as a reward system and treatment. This has Foucauldian ideas of governmentality and is a postmodern concept where the staff appear to be being set up as experts who are fit to review behaviour - whether anyone can judge correct behaviour is uncertain because whether correct behaviour actually exists is in question.

Despite the high expectations of their behaviour, the men are also viewed as having few abilities and little understanding. Therefore, ideas that the men's behaviour can reach such high standards are challenged as their ability is reportedly so low. Such repertoires function to illustrate how disabled and dangerous the men are. However, these ideas may be challenged as their rights and restrictions change as policy and/or staff become more progressive, independent of the men's behaviour.

Justifications of Detainment – From Ideology to Practice

Discourses are affected by history and culture, so my concern in the analysis was with which macro- and micro-discourse and policies constrained or enabled certain practices to exist within the MSU. The major discourses are illustrated by viewing the constraints and enablers of just one practice – the detaining of the men in the MSU.

<p><u>Justification for same treatment</u></p> <p><u>Discourses of sameness</u></p> <ol style="list-style-type: none"> 1. Everyone has a learning disability of some kind 2. They are entitled to the same rights and choices as everyone else 3. The men have the same hopes and wishes as everyone else 4. The men have abilities and can make contributions <p><u>Learning Disability is positive</u></p> <ol style="list-style-type: none"> 5. It was a great advantage when working on the LS 6. It means people receive services and opportunities that are denied others 7. There is pride in impairment 8. It means less responsibility or stress <p><u>Negative aspects of Security</u></p> <ol style="list-style-type: none"> 9. The men are not being treated 10. The men are separated from their loved ones 11. The men believe others in the MSU to be unkind and dangerous 12. The men are passive and lack ability and understanding 13. People should not live in NHS long stay hospital premises 14. The men are restricted in choice, privacy and movement <p><u>Repertoires of Rights</u></p> <ol style="list-style-type: none"> 15. national law and policy states men are entitled to same rights, choice, consent and privacy as everyone else 	<p><u>Justifications for Detainment</u></p> <p><u>Discourses of Difference:</u></p> <ol style="list-style-type: none"> 1) People with a learning disability are disadvantaged 2) Discourses of deficit 3) The men are patients with a diagnosis which separates them 4) The men are detained because they are dangerous criminals 5) The men are victims and vulnerable 6) The men are different from other people with a learning disability <p><u>Discourses of Deficits</u></p> <ol style="list-style-type: none"> 6) the men can't do 7) the men do not have a normal IQ 8) the men rarely have friends or jobs <p><u>Repertoires of Security</u></p> <ol style="list-style-type: none"> 9) Distance and mistrust in relationship 10) Prison Warden 11) Governmentality <p><u>Discourses of detainment and dangerousness</u></p> <ol style="list-style-type: none"> 12) The men are dangerous 13) Security is necessary for the good of society and for the men 14) To detain safely we need security 15) The men receive the specialist treatment they require 16) The men should be held in security because of what they have done. 17) Given the right opportunity the men can achieve <p><u>Repertoires of Restrictions</u></p> <ol style="list-style-type: none"> 18) Law and local policy restricts rights and choice (authoritative corroboration) 19) restrictions of basic rights choice and consent justified because of the men: 20) restrictions of basic rights choice and consent justified because of the staff: <p><u>Repertoires of Therapeutic Nursing</u></p> <ol style="list-style-type: none"> 21) Nursing values and skills 22) Help and treatment 23) Therapeutic relationship 24) Good staff relationships 25) Humour 26) Staff empower men 27) Staff take pleasure in their achievement 28) Men and staff enjoy each others company
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Figure 5: Justification for same treatment

As can be seen from Figure 5 those discourses which enable the men to be held in the MSU and treated differently from other offenders are those which contain elements defining the men as different from others. It is also apparent that those discourses which enable detainment and constrain the men from being treated the same are more numerous than those which enable their treatment as the same and constrain their detainment in the MSU. Discourses do not just represent the world, they construct it. It is similar to a paradigm; as what it is and how it is debated depend upon the different approaches available at the time - just as what we think, imagine, etc. are constructed by the discourses presently available. It is not surprising that alternatives to detaining men with a learning disability have not been sought as there are so many dominant discourses justifying their detainment. This thesis challenges such dominant discourses and offers alternative truths to be heard.

Implications for Future Research

More research is needed into the **efficacy of the evidence base for detention**. As the findings unearthed many paradoxes existing in the beliefs, justifications and ideologies of the participants about forensic practice, it may be that there are better alternatives than detaining young men for years in secure settings in order for them to receive treatment. Many more treatments are now moving towards **community-based interventions**, and as our evidence base increases in this area it may enable an exploration of other options rather than or alongside detainment.

There is also a need for exploration of the **criteria used for clinical judgments** – not just those which are legally required for, for example, consent and competency but also in the staff's ability to use criteria to judge risk and appropriateness of restrictions – the staff ability to make sound clinical judgements could be measured by psychometrics, or measured against other practitioners. Related to this is the need to **measure the efficacy of the grading system**; to measure its efficacy against and along side other interventions using control groups of men and to investigate a sound evidence base.

Finally, appropriate studies of **Staff and patient views should be used to inform future policy** to ensure a fairer and broader approach, not merely one steeped in tradition and historical stigma.

Please see Figure 6 for a table of implications for the study.

The Security-Therapy Paradox

The security-therapy paradox is central to forensic nursing practice and this thesis, yet the concepts appear in opposition to one another in ideologies – in fact forensic nursing has to embrace both to be successful; the men require safety and security whilst the staff use therapeutic relationships and techniques to enable their change to safer behaviour. In considering this paradox, critical practice is paramount.

The nursing personnel sphere that this thesis may influence includes: encouraging the developing knowledge and skill of nurses; sharing research findings; promoting evidence-based practice; articulating the nursing contribution to outcomes (particularly in terms of value); influencing the expertise, self-efficacy and satisfaction of nurses; engaging staff in learning activities and research; questioning present practice; and presenting findings (Zuzelo, 2003). This study will go some way to potentially influence many of the areas listed as it carefully considers the ideologies upon which many practices are based.

Implications for the men

The therapeutic relationship is of central importance in nursing (Scott, 2008). However, in forensic nursing there are justifications for distance (Dale, 2001). Critical analysis unearthed repertoires which justify distance and mistrust in the nurse-patient relationship; nurses being viewed as prison wardens and leaning towards security. Critical reflexivity shows that nurses are suspicious and believe that they rightly judge the men; using surveillance and report writing to aid in policing the behaviour of the men. The men reported feeling that they are not trusted and, in turn, fail fully to trust the staff who they view as part of the system which detains them. Such discourses apply blame; the staff argue that it is the men's behaviour which leads them to be observed constantly and the men blame the staff – when in fact the surveillance is based upon clinical, legal and policy judgements and is not the decision of individual nurses.

Critical action shows some nurses reportedly leaning towards security rather than therapy and other nurses vary in their opinions of security and may be more progressive – experience, qualifications and education may affect the nurse's view of this balance. This obviously has implications for this thesis in relation to educating nurses to challenge structural disadvantage and encourage empowerment and is an important part of forensic nursing practice development. Repertoires concerning governmentality were numerous in the data and are challenged by critical practice.

McCormack and Garbett (2003) suggest that changing practice requires us to work across all levels of the organisation, challenging ideas and encouraging practitioners to think creatively. One of the first and most influential parts of practice development is to raise awareness among colleagues, organisations and clients. This thesis will give a voice to the men – one which the staff may not have heard before - about the ideologies which affect so much of their lives and expectations.

Implications for Practice

Similarly, this gives a voice to staff who are not often heard and this is one of the most important roles of practice development. The staff here have helped in the opportunity critically to analyse the ideologies which underpin our practices, and help to create change through questioning what they do and why they do it.

The Therapy Role

Repertoires concerning the caring and compassionate roles of the nurse were frequently evident in the data and mirrored what literature and policy state as the caring and therapeutic roles of the nurse; the skills and attributes of a successful 'good' nurse¹²³. These repertoires include having good nursing values and skills, for the help and treatment they offer. The therapeutic relationship is demonstrated by, for example, being comforting and encouraging towards the men, good staff relationships and a non-judgmental approach mixed with humour. Importantly the men and the staff reported enjoying spending time together and during the observation of their relationship over the time

¹²³ Turnbull and Paterson, 1999; 99; Smith and Godfrey, 2002; Bjorkstrom et al, 2006; Lofmark, 2006.

of the LS and dissemination exercises this was apparently warm, friendly and therapeutic, despite the nurses' security duties¹²⁴. This aids effective treatment - something happens within this complex relationship, apparently against the odds, and the outcome is positive for the men and the staff (Dale and Gardner, 2001; 251-271).

The repertoires concerning the staff having a non-judgmental approach to the men, despite their index offence, demonstrated good nurse characteristics and challenge negative ideas of the staff. The staff enjoyed a close working relationship with each other. Such repertoires serve to promote positive aspects of the staff and demonstrate the many casual and close relationships in the MSU despite the hierarchical and powerful staff structure.

Humour played an important part in this setting regardless of its forensic nature. The men described enjoying the teasing of staff and, in turn, the staff used humour to deflect situations and the seriousness of the men's offences. Humour cements relationships and demonstrates warm and power-balanced relationships and legitimates teasing. Of course, these are not actually power-balanced relationships, and humour may be used to appear to lessen the power imbalance and raise the perceptible power of the men. Some repertoires suggest that the staff help the men to become empowered within the restrictions afforded by security. Such repertoires assume that the men require help to be empowered and legitimate their role as 'sick' and raise the status of staff who are viewed as doing a good job when, in fact, it is part of the staff's everyday duty.

In the interviews, I questioned the staff on why they claimed to get so much pleasure from the men's achievements (this was a common theme). Such repertoires talked of pleasure and pride, of loving to spend time with the men on a one-to-one basis, of enabling good rapport and functioned to show that the staff cared about the men and enjoyed their company – this is also found in the literature (Reed *et al*, 2007). They demonstrate respect for the men and legitimate the relationship as built on bonds of care, promoting staff as 'good' nurses with little need for change in practice. Whether their relationship was because of the characteristics of the staff or due to the men is questionable. Owing to the power imbalance, the men may have been left with little real choice as to whether to get on well

¹²⁴ Robinson and Reed (1996; 133-153 and 118-119) examined interactions between staff and patients in five forensic environments and found, similarly, that patients were positive about their interactions with staff.

with staff or not. Furthermore, the literature suggests that people with a learning disability may have a tendency towards trusting and forgiving characteristics, so they may remain friendly and warm towards the staff despite feeling aggrieved at their detention (Race, 2003; 215).

As the staff enjoy the men's company so much, this finding questions the discourses of dangerousness surrounding the men.

Implications for the men

These results show repertoires of mistrust and suspicion, where the staff and the men view each other negatively, therefore emphasising the positive aspects of the men to the staff (for example humour and fun) and the positive aspects of the staff to the men (such as being caring and non-judgmental) may enhance their relationships. The high importance of humour and fun in the therapeutic relationships may be understood and utilised by staff in developing and maintaining effective therapeutic relationships. The multifaceted needs of patients impose complex demands upon the staff. Effective supervision in practice is essential for reflection and regular continuing professional development to ensure staff do not become complacent about the effects of detention and lean towards security rather than therapy.

Raising awareness of alternative views of forensic practice and restrictions of rights and choice may impact upon nurses' views and filter into policy to effect change. Power-sharing relationships in nursing practice are generally problematic because of the '*patriarchal ideology of power associated with the medical model of care*' (Gallant *et al* page 153, cited Scott, 2008; 243). This may be more so in forensic practice which has massive overtones of power and is historically steeped in the medical model of health care and lacking in collaboration in care and policy development. It appears from the literature that nurses are not traditionally effective in equalising such power relationships. Education has a role here and is responsible for producing competent practitioners who can relate well and work in partnership (Scott, 2008). By raising awareness of the difficulties with the power relationships in forensic settings, the findings of this thesis may impact upon how nurses perceive, develop and maintain such relationships.

There is a need to question the influence of the medical model and its definitions in contrast to the positive aspects of having a learning disability and we can add great weight to the contribution of service users and carers in education and make a case for more affirmative and social models in caring for offenders. As this is a professional doctoral thesis it may help to narrow the theory-practice gap (Ellis and Lee, 2005); since through education we may develop practice and, in turn, enhance the quality of care and life chances of the men through enabling nurses to understand more about:

- the therapy/security paradox for students
- implications for the men
- positives and negatives of forensic practice
- the men's views

Policy changes alter restrictions and security but the staff and the men have little influence on this (UKCC and University of Central Lancashire, 1999; 123-132). The staff are managing complex situations and are experienced and skilled practitioners, yet have little say in the processes governing their work and the lives of the men – this is not merely a local issue but has national implications. The men and the staff should contribute to the development of policy.

Implications for Practice

There is a need for a high level of relational education, especially in showing staff the importance of equalising relationships and work in partnership in forensic practice (Scott, 2008). Emphasising the high importance of humour and fun in the therapeutic relationships would be interesting and useful to all nursing practice, but particularly so in forensic settings. If we can discover how best to utilise humour we might use it as another tool effectively to engage patients in treatments and interventions which increase their life chances - it is used in relational security as it successfully cements therapeutic relationships.

Security is dominated by the ideology of the governmentality of the staff and the dangerousness of the men. Practitioners may examine the findings of this study and utilise them as a framework to

explore their own ideologies and that of the men's perceptions of the staff and their environment. In examining these they may begin to reflect upon their own ideas of governmentality and the justifications for security, restrictions and their own practice. The issues concerning the 'good' characteristics of nurses and their importance in ethical practice may have implications for nurse recruitment and training, especially for forensic practice (DoH, 2008b; 69-75).

Continuing Professional Development

The findings of this thesis demonstrate the importance of relational and caring qualities in forensic practice and education – in enhancing positive aspects of forensic practice and 'good nurse' qualities in practitioners. Importantly, if the mentors that the student nurses meet in practice do not demonstrate and communicate 'good nursing' qualities then this becomes an issue for all nurse education (Scott, 2008). Reflection has been shown to be a vital nursing skill to enhance practice (Johns, 2002; 1-20). Continuing professional development aids in the advancement of reflection skills, and the findings of this thesis show the significance of helping forensic nurses to focus their reflection on:

- ideology
- skills, knowledge and attitudes
- prejudice and truths about disability
- forensic practice and the therapeutic relationship
- the effects of a poor and dysfunctional background, abuse and institutional living on the people they care for

Forensic education may help the student to examine the positives and negatives of the environment for patients and staff, not merely from a legal, treatment and policy standpoint; this thesis adds to such knowledge with the insights from the men's and staffs' perspective and is useful for critical practice and reflexivity (Barnett, 1997; 102-115.).

Staff supervision is of utmost importance in nursing practice (Johansson *et al*, 2006), but particularly so in forensic settings where anxiety and depression are the '*emotional by-products of treating patients*' (Dale, 2001; 136). Coping strategies utilised by nursing staff were shown to include humour and developing the trusting relationships demonstrated between the staff, and the staff and the men.

Workforce Development

Forensic education available for all staff working in forensic settings would be advantageous as they are very complicated environments in which to practice. Nursing assistants may benefit as the continued professionalisation of nursing means that unqualified nurses have increasing patient contact (at the expense of qualified nurses having patient contact)¹²⁵. The findings suggested that unqualified nurses would benefit from education including materials on assessment, ethics, qualities, morals and values which underpin forensic practice – that is, the values and attributes that were shown to be important here¹²⁶.

Pre-registration Education

A study by Gannon-Leary (2008) found that higher education students were not aware of the research taking place in their own university by the staff who were teaching them. She recommended that lecturing staff should let the students know about their projects through teaching, especially emphasising the relevance of research to the students and to real life, the transferable skills and the use of such research in practice (Gannon-Leary, 2008). In my experience, using my research helps when trying to teach research to students as it brings the subject alive and gives it real meaning for the students and highlights practice issues. Further emphasis on 'good nurse' attributes in educating for forensic practice is essential and should really begin in pre-registration nurse education.

Implications for Future Research

'The challenges and opportunities for forensic mental health R&D are similar to those for other non-acute, non-medical services and disciplines. There is a scarcity of high-calibre specialist researchers in all disciplines and therefore a need to develop capacity, particularly at Doctorate and post-doctorate levels.' (Clifton and Harvey, 2001; 64)

There are several issues highlighted by this research which may be useful to pursue in more depth in the future (Please see Figure 6).

¹²⁵ Something acknowledged as historically recognised by Robinson and Reed (1996; 133-153), who found that nursing staff only spent 6.5 percent of their time carrying out individualised care whilst spending 25 percent of their time on administration duties.

¹²⁶ Scott, 2008; DoH, 2008c; 12-30; DoH, 2008b; 69-75; Sookoo et al, 2008

The difficulties in the **security-therapy paradox** may be examined in more depth to enable us to tease out just what it is that enables nurses to engage in both, apparently opposite, activities and behaviours successfully.

Research into the value of the **caring role in forensic practice**, its possible effects on the nurse, the relationship, the patients and their outcomes may be useful.

Research into **qualities of the 'good nurse'** would be useful for practice development – our techniques and competencies are easier to measure, therefore receive more attention from researchers than our nursing qualities (Robinson and Reed, 1996; 2-3 and 150-156; Scott, 2008; DoH, 2008d).

It may be important to look at the **coping strategies that forensic nurses use** to successfully compartmentalise each paradoxical behaviour/belief at appropriate times, and what barriers might exist to the successful utilisation of both.

Patient practice-focussed research helps to effect positive change and develop ethical, skilled and knowledgeable practitioners (Ellis, 2006). Importantly, our **research should be led by user perspectives**, be appropriate for nursing practice, develop relevant methodologies, influence policy, and ensure that **nurses become leaders in the development of evidence-based nursing knowledge** and that this is articulated to develop forensic nursing appropriately (Ellis, 2006). Finally there is a general need to measure the **outcomes of user involvement in education** concerning practice, patient outcomes and on the students' education in general.

Future implications

The main conclusions of this study follow:

Firstly, there are multiple truths about people with a learning disability, people living in secure settings and forensic practice. The existence of such multiple truths enables understood facts regarding these issues and practices to be questioned.

Paradoxical ideologies exist regarding many aspects of having a learning disability, living in secure settings and forensic practice: six paradoxes have been examined in detail in this thesis:

1. The men are the same – the men are different
2. Learning disability is positive – learning disability is negative
3. Detainment is positive – detainment is negative
4. Low expectations of the men – high expectations of the men's behaviour
5. The men are entitled to the same rights as everyone else– the men's rights are restricted
6. Staff are caring and therapeutic – staff maintain security and are part of the system that detains the men

Having a learning disability has been found to be positive, even for people living in secure settings, it is important that this is disseminated as it may add to the 'accentuation of the positive' (Goodley and Armstrong, 2001; 12) essential for the emancipation of people with a learning disability.

There are arguments for and against detention; those for detention appear dominant and are more numerous in the data. Arguments against the detention of people with a learning disability who come into contact with the CJS are often hidden, yet we have little evidence base of efficacy of our interventions (detention is a form of intervention in itself). It is important that when we deprive people of their liberty in specialist settings for treatment, that we have sound evidence base for our practice. Staff in such settings are often stereotyped as prison wardens, but the data showed many positive aspects of practice and 'good nurse' characteristics in the staff. How the staff develop and maintain such practice in this complex environment is of great interest to many aspects of nursing practice. The 'good nurse' attributes are difficult to measure, and nursing metrics of compassion and their effects on patient outcomes have recent significance to be validated by research and patient involvement, especially in identifying compassion metrics so that we may engage with tools that will help us to deliver high quality care (DoH, 2008d).

The '*State of the art metrics for nursing*' report (DoH, 2008d) looks at the evidence for nurse-sensitive indicators and which are useful. It identifies several indicators which include:

- aspects of the patients behaviour,

- experience
- or health status
- and are focussed on
 - nursing interventions,
 - staff satisfaction
 - nursing system characteristics (for example, staffing levels or skill mix).

(DoH, 2008d).

Humour was found to be very important for the study, the men, the staff, and their relationships within the MSU. Further investigation into humour and its effects on efficacy of relationships (which are key to positive outcomes for patients) and how it is used as a coping mechanism for the men and the staff may lead to greater understanding of the applications of humour in practice.

The findings of this thesis will be disseminated through peer-reviewed journals, nursing literature and conferences. The men may use their facilitation abilities to train future and present staff about user perspectives in forensic environments and disseminate lessons to be learned about the effects of secure services on staff and patients. It is important that the men are aware of the nurses positive feelings and the nurses are aware of the men's positive feelings for the staff. Further, policy makers would be made aware of the findings from this study to inform future developments. The findings will be integrated into pre- and post-registration education locally. After dissemination, future services and policy may be cognisant of the men's views, good practice that exists and the positive aspects of men with a learning disability in secure services.

Personal Reflections

I feel that my conceptual conclusions are accurate; I can only answer the research questions and close the virtual research loop if my theoretical perspectives, research design, methodology and methods were coherent and appropriately integrated. I successfully identified gaps in knowledge through a thorough literature search which identified gaps such as: positive discourses of learning disabilities and forensic practice; exposition of the views of the men and staff and using discourse as a route to the ideologies underpinning forensic practice.

There is a lot of 'me' in this thesis, I exposed my beliefs and feelings early on as is essential in qualitative studies of this kind, and in doing so my personal views come through loud and clear. However, I wish to make clear that in criticising and questioning detention in secure settings that I am not, for example, advocating for gaol for people with a learning disability as it has been shown not to be suitable for some people, and health services may be more appropriate (*No one Knows*, Prison Reform Trust, 2007b; Joseph). Nor am I intending to show disrespect for legislation. It just appears unfair that the men can be held by virtue of their having a learning disability for so much longer than their non-disabled counterparts whether their counterparts are a risk or not.

The study may be criticised as it is not deductive and is steeped in my own beliefs, therefore I could easily be accused of collecting data which fits with my personal theories. I feel that I have avoided such criticism through acknowledging my world view in the preface and also through enabling the reader to view all of the main arguments, laid out side by side, demonstrating the multiple truths that I found in the data, so that they s/he can make up her/his own mind. I do of course, make interpretations, which may or may not be accurate, but I have made such interpretations transparent in the data.

On reflection the study may have benefitted from some additions to the data set. For example I could have included text from the media, representing a strong lay person/societal view. I would have liked to have concentrated more on the relationships and on the 'good nurse' characteristics in the interviews and focus groups, where more rich data may have been acquired. The study may have also benefitted from some quantitative measures in order to make it more generalisable; I could have measured nursing attitudes for example and used a larger sample of nurses. However, as the data used was from another study this would have been difficult to justify to the participants (and sponsors) and as my quest was for multiple truths; such measures just would not fit.

There remains a lack of specific literature around forensic practice and learning disabilities therefore, I had to utilise literature which was conceptually relevant to my thesis in order to compensate. I created a web of ideas (we often have to do this when studying learning disabilities) using this conceptually similar literature around related disciplines and the small amount of specific literature available.

The specific research questions were born out of the gaps in the literature and the philosophical disputes around disability, learning disabilities, forensic practice and ideologies (which had always fascinated me). All of these issues appeared under-researched in relation to forensic practice and are important to a profession lacking in evidence base. The research questions were also practical: do-able; on time; with the resources and data available; and through employment of appropriate methodologies.

The methodology was chosen firstly though my fascination with ideology, which led me to discourse; the study of which, of course led me to Foucault and the loop was closed when Foucault showed me the way to critical discourse analysis. As they share a similar philosophical stance in their: criticism of similar social issues; viewing discourse as a concept where meanings are not fixed and are multiple; the challenge to truths and unearthing non-dominant truth; ideas of power; and the construction of objects and subjects - which fits perfectly when studying an oppressed group such as people with a learning disability.

Through the utilisation of appropriate research design and methods I have made additions to the evidence base for forensic practice for people with a learning disability, unearthed positive aspects of the men and was pleasantly surprised to discover so many repertoires of positive characteristics of the men and of the staff; however, I never doubted that there were very many – I was only surprised at finding so many.

I did not set out to criticise nurses – after all I am one. As such I moved from outsider to insider status and back again at different points in the research.

The advantages of being an insider included: an acknowledgement of my interpretations as I did not have to be objective as an author; I know the code; the staff saw me as legitimate in the field which gave me in-group access; I could pick up on nuances and insight and easily built up equal rapports with the staff and the men.

However there were also disadvantages to my insider status: as I could have value conflicts (after-all, I did not want to find any reports of poor practice from my own profession); I could have an overly

positive bias; and importantly, as I knew the code this meant that I was in danger of becoming blind to the ordinary and familiar and could miss vital data.

Therefore it was important that I reflected constantly on my insider status and which insider characteristics were advantageous and hazardous to the study and ensure that I kept to my boundaries as a researcher and a participant – and not as a nurse.

This was significant as I feel nurses generally do a good job often under difficult circumstances and despite the multifaceted issues within this setting. It was essential that I acknowledge and keep in check my own biases. In doing so I hope that I have unearthed enough positive discourses about forensic practice and the attributes of forensic nurses for people with a learning disability to begin to develop positive discourses about the work that we do in this complex environment.

During my time with the participants, I found a welcoming, productive and above all warm set of relationships; given the mistrust, policy, legislation, restrictions and rules placed upon them, their relationships were expressed as affectionate and therapeutic. The Trust and the staff are research-focussed and patient-centred and I so enjoyed my time on the MSU to the extent that I am allowed to continue to return to work with the men – they are finding it difficult to get rid of me. The main reasons for my persistence are the pleasure I have in the men's company and the surprising things I continue to learn.

I feel content in that – through using their own words - I demonstrated the men's very unique personalities and reported the general attributes and talents that I found. I unearthed positive discourses regarding forensic practice and concerning the people whom we serve, and I am able truly to report and disseminate them.

Figure 6 : Summary table of future implications of this study.

Area	Implications
Education	<p>Service users:</p> <ul style="list-style-type: none"> - participation in student learning may enable a less medicalised and more social view of learning disabilities <p>Reduce theory-practice gap:</p> <ul style="list-style-type: none"> - through doctoral thesis informing practice and enhancing education of nurses through inclusion in the curriculum, including: therapy-security paradox; implications of detainment for the men; positives and negatives of forensic practice; and the men's views - enabling students the benefit of research by their own lecturers emphasising relevance of research to real life practice and bringing research to life <p>Relational education:</p> <ul style="list-style-type: none"> - importance of equalising nurse-patient relationships - importance of humour and fun in therapeutic relationships <p>Tool for reflection and reflexivity – the findings of this study may be used as a framework for practitioners to explore:</p> <ul style="list-style-type: none"> - skills knowledge and attitudes - their own ideologies - the men's perceptions of the staff - their own ideas of governmentality - justifications for security - prejudice and truths about disability - forensic practice and the therapeutic relationship - the effects of poor life chances on the men - effects of detention and institutionalisation on the men

	<p>Good nurse characteristics:</p> <ul style="list-style-type: none"> - disseminating findings to student nurses (essential that it begin in pre-registration nurse education) - and nurses accessing post qualifying studies; including mentors of student nurses <p>Workforce development:</p> <ul style="list-style-type: none"> - unqualified nursing staff have increasing patient contact – this group of staff may also benefit from education relating to the findings of this study including: assessment; ethics, qualities, morals and values underpinning practice shown to be important in this study
Research	<p>Participatory research:</p> <ul style="list-style-type: none"> - affirmative views of the men and their contribution to the study, its dissemination and the facilitation of the findings to other men with disability may change views of the use of people with a learning disability to academic work. <p>Practice:</p> <ul style="list-style-type: none"> - efficacy in evidence for detention may be measured against efficacy and recidivism for community based interventions - research into the detrimental effects of the men being separated from loved ones, far from home would be useful to determine possible detrimental effects of detention - paucity of research into relationships in forensic settings. – just how do nurses and patients develop and maintain such relationships in such complex environments <p>Interventions:</p> <ul style="list-style-type: none"> – evidence base for the grading system, its theoretical base, perhaps measured with a control group using another intervention <p>Clinical judgements:</p> <ul style="list-style-type: none"> – measuring staff skill and competence in assessing and managing risk and ability to make sound clinical judgments relating to restrictions on the men's choices

	<p>Security-therapy paradox:</p> <ul style="list-style-type: none"> - research may tease out exactly what enables nurses to engage successfully in both activities and behaviours <p>Humour:</p> <ul style="list-style-type: none"> - use of humour and its employ in forensic settings, for behaviour and development in relationships between staff and men and the staff group - how best to utilise humour as a tool to engage patients in treatments and interventions - The usefulness of humour in research and academic pursuits - the use of humour in the coping mechanisms of the staff and the men <p>Good nurse characteristics:</p> <ul style="list-style-type: none"> - research in this area is scant as techniques and competencies are easier to measure. - Nursing metrics effectively measuring compassion may be useful for practice development across practice areas
Practice	<p>Critical reflection:</p> <ul style="list-style-type: none"> - staff listening to men's views of their practice can inform their critical reflection - knowledge of staffs own paradoxical ideologies aid in reflection - reflection upon ideologies underpinning the importance of security and therapy - power relationships and partnerships in care can be reflected upon due to the findings of this study <p>Understanding:</p> <ul style="list-style-type: none"> - between the men and the staff may be enhanced as they listen to the views of one another and the positive repertoires used by both parties about each other. <p>Assessing skill and efficacy of ability to judge behaviour, choice and risk and education if required</p>
	<p>Negative ideas of difference enable the men to be treated in a different way to other criminals and others with learning disability:</p>

<p>Policy</p>	<p>– this thesis questions this negative view of difference and of the men. Discourses of sameness challenge the view that the men are very different from others in society</p> <p>Affirmation model may be the way forward as people with a learning disability can be viewed as different, without normalising discourses and still can be valued for who they are, if their experiences are re-evaluated in positive terms. The positive discourses and ideologies unearthed in this study may be useful to dispel myths, develop an affirmative view and increase expectations of, and for, the men</p> <p>Staff and patient views inform future policy</p> <p>Staff and men should be involved in policy development</p> <p>Challenge structural disadvantage suffered by the men and the discrimination, poverty, and the disabling effects of stigma. The lack of appropriate services and perhaps earlier interventions which may contribute to offences and detainment</p>
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Appendix A Appendices

Appendix One - Levels of security and People with a learning disability that come into contact with the CJS

There are several issues which may effect people with a learning disability when they are arrested. The *No One Knows* report (*Prison Reform Trust*, 2007b) state that police officers often prefer that no further action is taken for people with a learning disability – those officers proceeding to charges doing so, so that they should receive proper treatment and help. Disposal to health care is the preferred option with mentally disordered offenders but is not the only factor by which they are diverted to health care (*Home Office Circular 66/90; Home Office/ DoH circular 12/95*, cited in Dale *et al*, 2001).

Firstly, the caution is a long statement with many different and complex parts to it and people with a learning disability may not be inclined to say they don't understand (Hayes, 2002). At arrest it is the Custody Officer who is responsible for identifying whether the offender needs further professional assessment. This relies heavily upon other professionals like psychiatrists and nurses to be able to recognize learning disability and perhaps train police officers (Hayes, 2002).

The Custody Officer has to recognize the signs of learning disability in order to call for further consultation. The officer reads the offender their rights and gives them a leaflet. He is then required to check their level of understanding as:

- They may not understand the right to remain silent.
- The right to a solicitor
- Have limited reading skills.

The offender may not be capable of consenting to being questioned, having a solicitor or waiving any of his rights. Only if the learning disability is identified will the person be treated fairly (Hayes, 2002). Therefore, they are at risk of making false statements and confessions, or of not being interviewed because of such vulnerabilities.

When acting as witnesses or suspects people with a learning disability have protection under The Police and Criminal Evidence Act (PACE) Codes of Practice (Home Office 1995 and The Youth and Criminal Evidence Act, 1999). But when giving statements the reliability of witnesses with learning disabilities is sometimes questioned because of assumptions about impaired memory, vulnerability and difficulty to cope with the uncertainty of questioning (Gudjonsson and Henry, 2003).

But people with a learning disability actually can give sound testimonies (Kebbell and Hatton, 1999), especially when using open questions and when the interviews are structured correctly (guidance by Tully and Cahill, 1984, is summarised in Grant *et al*, 2005). Use of the Gudjonsson Suggestibility Scale (GSS) (Gudjonsson, 1997) may be particularly useful in legal interviewing as it scores the ability of the witness to resist suggestibility. Beail (2002) believes that the low suggestibility scores in people with a learning disability are based upon memory for facts, not episodic memory for which people with a learning disability have better recall. This is confirmed by a study by White and Willner (2003) who found that the recall was higher, and the suggestibility lower, in people with a learning disability who had actually witnessed an event rather than just been told about it – so false statements and confessions may be less likely.

Court may be frightening for any one, but people with a learning disability may be more vulnerable to the complex language and protocols which exist in this arena. With reference to the complex language and questioning styles which can be particularly confusing for people with a learning disability, O'Kelly *et al* (2003) found that judges did not intervene to modify this process and ensure a fair trial. In law *actus rea* is a behaviour or its consequences and *mens rea* – is the person's state of mind. Both of these need to be considered when offences have taken place. It is often believed that people with a learning disability cannot have the capability to know what is right and what is wrong.

The court sometimes takes the learning disability into account during trial and sentencing but there are some strict criteria used; for example the criterion for having a learning disability is considered to be an IQ of 70 or below. The judge is required to ask for expert evidence if s/he suspects that the person may have a learning disability. Obviously, this may not always be recognised and expertise sought (Grant *et al*, 2005).

Levels of Security

Within the health sector there are different levels of provision and secure environments are provided for patients who have learning disabilities, at low, medium and high levels. High security offers a higher secure service which equates with some security in prisons, but within a health setting and is generally considered to be less appropriate for people with a learning disability (Skelly, 2001).

Medium security offers secure environments for people who cannot be safely cared for in low security, but do not require high security (UKCC and University of Central Lancashire (UCLAN), 1999). There are many Medium Secure Units (MSUs) in England. This study took place in one such MSU. The men are not allowed to leave this facility unless they have the appropriate supervision and leave from the MHA (1983). The doors are locked, there are security cameras inside and outside of the buildings and the staff carry alarms. The movement of the staff and the men is closely observed by nursing and security staff. The men's physical, educational and occupational needs are cared for within the MSU. People held in low security often have short term needs, need for assessment in secure environments or, especially in services for people with a learning disability, require longer term, or slow stream care (UKCC and UCLAN, 1999). Such units will be locked, but the people who are cared for here may have leave to visit certain places at specific times, without supervision. The people in low secure settings often use general hospital and community facilities, but commonly under strict supervision.

The level of security appears not very exact and relies heavily upon the reporting skills and judgements of practitioners. Maden *et al* (1995), considered the treatment needs of such patients and suggested that it was difficult to identify patient characteristics which distinguished the high secure from less secure environments, although most offenders in high security tended to be there because of sexual disorders. Those with a learning disability tended to be in lower security and the numbers have reduced in high security recently, those with a learning disability remaining in high security being those difficult to place elsewhere. Maden *et al* (1995) state:

'The point emerging from many of these tables is that the distinction between patients needing maximum or medium security is hard to pin down. It is a matter of degree or judgement, rather than a clear, qualitative difference' (Cited UKCC and UCLAN, 1999; 27).

Maden *et al* (1995) compiled a list of issues indicated by the patients' clinical teams as determining a need for security and presenting as possible obstacles to discharge. These appear to be linked to ideas of deficit and difference, such as the offence not being understood by the patient and likely non-co-operation with supervision and medication.

Forensic patients have a wide range of needs. Patients with mental health problems held in forensic services include adults who:

- Have not committed an offence, but whose behaviour brings them to the attention of the police.
- Have not committed an offence but whose illness or behaviour leads to their being held under the Mental Health Act, sometimes in secure accommodation; those unfit to plead, "insane on arraignment" or "at her majesty's pleasure".
- Have committed a minor offence but their chief need is for treatment and whom it is not in the public interest to detain or act against.
- Have committed an offence and who will be prosecuted but whose mental health problems are such that a prison sentence would be an improper disposal; i.e. they require treatment.
- Have committed an offence and who will be prosecuted and may enter the prison population with a mental health problem or develop a mental health problem in prison (UKCC and UCLAN, 1999; 14-35).

Appendix Two - Culture and Change

According to Geert Hofstede in the 1970s people's approaches to their work are explained by four separate dimensions: power distance, uncertainty avoidance, individualism and masculinity (cited Stanley and Swan, 2005; 171). Power distance relates to how much individuals are able to recognise an imbalance in the distribution of power, affluence and status. Cultures in organisations like the National Health Service rely heavily on unequal distributions of power and status. In forensic nursing settings there are not only high levels of hierarchy throughout the staff team, but a huge imbalance of power between the staff and the men held there. Therefore this setting has a high power distance dimension.

Uncertainty avoidance relates to how much people feel uncomfortable as a result of uncertainty and risk. Forensic settings tend towards high uncertainty avoidance, as whilst they have a responsibility to provide current therapeutic interventions, this is tempered by the need for evidence based practice and the responsibility for security, which may impede innovation. Individualism relates to how much people in a culture are supposed to act autonomously. In forensic settings there is a sense of cohesiveness amongst the staff team, and because of this setting it might be more necessary to act as a team and have relationships of trust and loyalty, rather than uniqueness and individuality, as staff may have to rely on each other for emotional support and physical safety during untoward incidents. Masculinity refers to the separation of roles in society, particularly gender roles.

Highly masculine cultures have such a differentiation and prefer career progression and high earnings. Forensic environments whilst seen as highly masculine on the surface (probably related to links with custodial care cultures), but tend to be less masculine in relation to the importance of inter personal relationships between team members and of the nursing vocation.

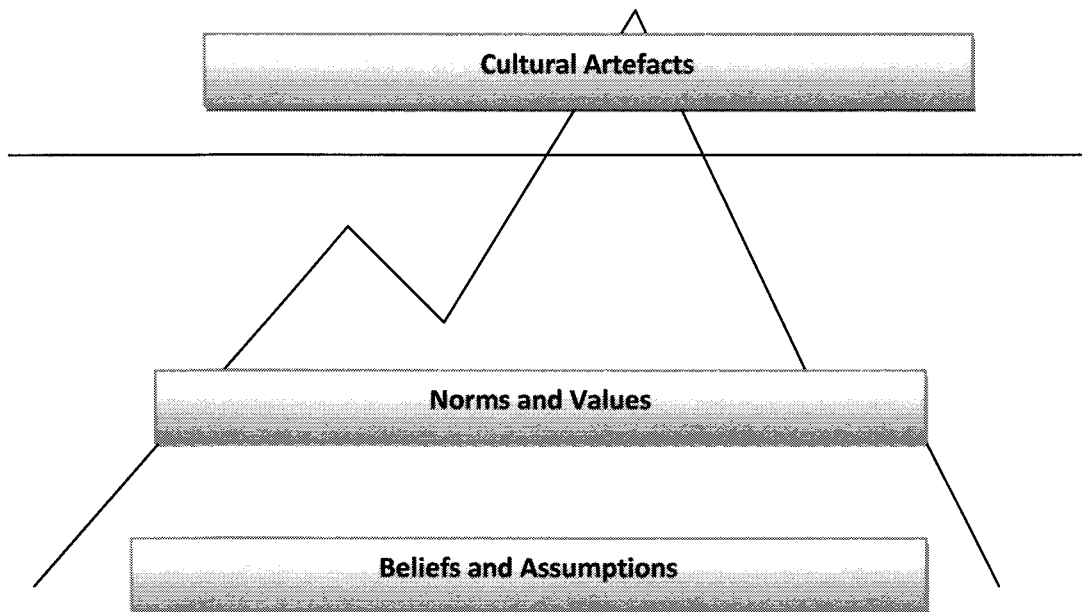
Levels of Organisational Culture

Schein (1992) defined a culture as:

- 'A pattern of shared basic assumptions
- invented, discovered or developed by a given group
- which learns to cope with its problems of external adaptation and internal integration
- has worked well enough to be considered valid and therefore
- is taught to new members of the group
- as the correct way to perceive, think and feel in relation to those problems'

(Cited Stanley and Swan, 2005; 174).

As the culture shares basic beliefs and is usually bonded in behaviour, cultures which are considered strong may be rigid and inflexible, entrenching their members into certain ways of working, whereas weaker cultures appear more adaptable. Despite this strong cultures hold people together, helping them to reach common goals, and are considered to be positive, in that they may lead organisational improvements in performance, most especially when they are open to adaptation and change. Elgar Schein (see Stanley and Swan, 2005) described three basic levels of organisational culture in terms of an iceberg:



Developed from (Stanley and Swan, 2005)
Figure 7: Schein's Organisational Cultural Level Iceberg

Beliefs and Assumptions

At the most basic level organisational culture begins with beliefs about:

- Human nature
- Reality and truth
- Relationships
- Values regarding innovation/conformity

Of course inconsistencies in these beliefs occur within the culture, and the culture itself is decided by the ways in which the organisation resolves these. Beliefs and assumptions are usually unconscious and hidden within the organisation (Stanley and Swan, 2005).

Norms and Values

Values within the culture of an organisation are what the organisation views as important and norms tell the individuals how to behave, what is acceptable and unacceptable. They constitute a set of principles which govern the members' behaviour. Norms which are rewarded are those which are linked to organisationally valued outcomes. These are more conscious than beliefs and assumptions, but are still hidden (Stanley and Swan, 2005; 169-191).

Artefacts

These are the tip of the iceberg, the level which is visible to the organisation. They are the expression of the values and norms, the beliefs and assumptions which underlie them. They include environmental manifestations like building design and physical manifestations like uniforms worn by the staff. The artefacts even express how the organisational members relate to one another, through rituals and language. All of the artefacts perpetuate the culture, as well as describe it, "*[artefacts] ... are easy to describe, but difficult to decipher*" (Stanley and Swann, 2005; 172).

In fact, investigations into service quality and abuse of people with a learning disability rely upon such artefacts for auditing the service. As beliefs and assumptions and norms and values are manifest in the artefacts of an organisational culture, it is believed that they reflect the behaviour of the organisational members (Stanley and Swan, 2005; 169-191).

Subcultures

According to Stanley and Swan (2005; 169-191), subgroups may form in organisations in specific occupations and hierarchical levels of the organisation, and may also be historically based within the organisation.

Organisations, though, are subject to change and have to develop to survive. Subcultures are required to develop new ideas and ways of thinking about issues and may eventually grow new cultures, as change begins with pluralistic influences upon ideology.

Key to understanding organisational change and service development are the drivers of cultural changes which occur. Figure 8, which I developed from literature, illustrates the cycle of cultural change in organisations. It shows how pluralistic influences change beliefs and this becomes reflected in national policy and legislation. This is then reflected in local policy as services operationalise the changes. The organisation takes on new norms and beliefs and eventually the members of the organisation take up those new norms and beliefs as they begin to see how they work positively. This leads to cultural change in which, due to relationships or specific beliefs, sub-cultures may form. In cases where the norms and beliefs of the organisation rejected, the sub-cultural group may remain fixed in the old ideas. However, sub-cultures may be useful, as they may lead to a different way of thinking as, all new ideologies, norms and beliefs begin as sub-cultures; they begin as ideas different than those held by the rest of current society, expounded by a few people.

As time progresses new developments emerge and pressure groups and other pluralistic influences lead to a change in belief; and it too becomes reflected in national policy and legislation. This replaces the old beliefs; and the cycle begins again.

Auditing Artefacts

Individual level

This level relates to the characteristics of the people with a learning disability using the service and their relationships with staff, other service users, family members and outside professionals. Primary factors here include levels of support, programmes of activity, behavioural interventions and record keeping. The culture of abuse is characterised here by:

- the staff team being inward-looking, punitive and intimidating
- carrying out routinised care
- staff having control of private spaces

House level

This level describes the support staff provide, and staff and management cultures. It includes staff training; management and supervision; record keeping; monitoring systems; functional analysis; risk; physical restraint; personal care; and adult protection. Here an abusive culture is characterised by:

- Management distances itself from problems
- Culture shows features of corruption of care, such as neutralisation of moral concerns
- Staff competence low in managing behaviours
- Ineffective staffing
- Weak manager, avoiding confrontation
- Staff developed inappropriate practices
- Little understanding of norms amongst staff

Professional level

This level analyses multi-disciplinary working, especially case management and team work.

The Organisational Level

This is concerned with the processes of the organisation, including inter-agency working; planning, purchasing and commissioning; inspection and audit; development and operationalisation of policies, procedures and guidelines; and the relationships of the management at the service level and the management at the organisation level. Here an abusive culture is characterised by:

- Lack of regular contact with service
- Service resists management intervention
- Management fails to control

Figure 8. Developed from Stanley and Swan, 2005; 169-191.

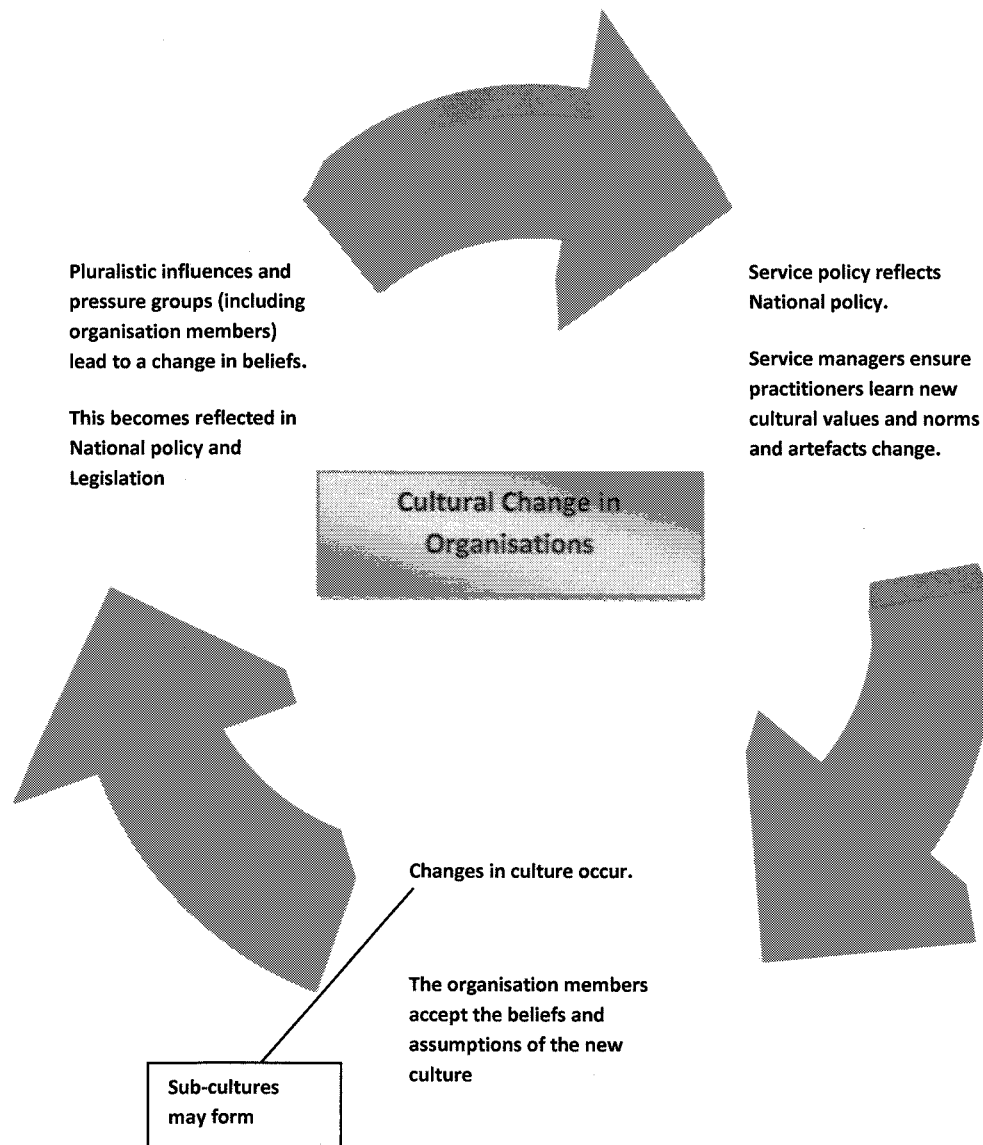


Figure 8: Illustration of the cyclic nature of Cultural Change in Organisations

Culture of abuse

This is characterised by isolation of staff from the rest of the organisation, from peer support and supervision. The staff are also resistant of help from external professionals. The culture here is one of dishonesty, lack of team work and lack of trust.

Quality of life

It is notoriously difficult to measure quality of life but it is generally agreed that qualitative rather than quantitative measures are preferred (Stanley and Swan, 2005; 169-191). Problems with the normative values of researchers may also cause problems, for example, community living is thought to add to quality of life measures, but community living does not ensure integration into the community. Similarly, choices and advocacy do not necessarily equal happiness as self determination has not yet been proven to be linked with quality of life, and instead can be linked to added stress (Stanley and Swan, 2005).

It is not within the scope of this study to audit the artefacts of the MSU. They are mentioned merely to give insight into the various artefacts that can exist – through exploring the discourses in the MSU some of them are apparent (for example routinised care and staff having control over private spaces) and in the results of this study.

Appendix Three: Abstract, Description, Aims and Purpose of the LS

Abstract

People with learning disabilities are increasingly asked to participate in research and this means they need to give informed consent. The literature suggests that, to date, there are a number of common approaches used to inform people with learning difficulties about research such as simplifying information sheets, reading out the information etc. However, there has not been any research into the effectiveness of current approaches to gaining informed consent. This study identified some of the key processes that enable people with learning disabilities to understand research, ethics and consent and ways in which researchers can work more effectively with people with learning disabilities in order to achieve informed participation in research. It highlighted the benefits of a participatory research, both for the participants and for the research process itself.

People with learning disabilities have traditionally been researched 'upon' rather than 'with', meaning researchers and academics make decisions not only about what is important to research, but also how that research is to be carried out (DoH, 2003; Northway, 2000a). This study used a facilitated collaborative action research (FCAR) approach which involved all participants in the research (the academic researchers, men with a learning disability living in a forensic setting and the nursing staff who work with them) becoming researchers in their own right. The approach involved enabling collaborative discussions and using multiple ways of engaging with presenting and collecting information. It used a longitudinal rather than one-off approach, allowing for repetitions of information and the revisiting of thoughts and ideas (a recursive process) to add breadth and depth to the data. It also involved having fun. The results suggest that the longitudinal collaborative approach was key to developing understanding in relation to informed consent.

There were additional direct benefits for the men, including opportunities for intellectual stimulation not linked to their health or index offence, skill and knowledge development, improved self esteem and confidence and providing an opportunity for further developing relationships with staff. The staff involved also learnt about research, developed other aspects of their relationship with the men, and have been involved in the revealing of capabilities in the men that have surprised and surpassed expectations. Some men enrolled at the local University to gain accreditation for their work.

The process of doing the research raised issues about how ability to consent is decided. All the men in this research were deemed able to consent. At the beginning of the project it was clear that many of the men had little understanding about research. At the end of the research at least one man was still unable to understand the notion of research and the nature of the decisions that need to be made when considering participation.

From this work, the researchers have developed

- i) a framework for engaging similar populations in thinking about participating in research. Entitled "Understanding Research", it includes facilitator and student information, written in accessible format, to enable people with learning disabilities both to participate in and ultimately facilitate the framework.
- ii) a set of principles for researchers working with people with learning disabilities.

(Cook and Inglis, 2008, abstract from Final Report, pp 12 and 13).

Understanding research, consent and ethics: a participatory research methodology in a medium secure unit for men with a learning disability

Marginalised and vulnerable people, like people with a learning disability have traditionally been excluded from meaningful involvement in research and there has commonly been a disproportionate relationship between researcher and participant.

An important barrier to true participation is the methods that are used in traditional research, which are intricate and abstract and do not easily lend themselves to involvement by people with a learning

disability. However, the LS aims authentically to involve men with a learning disability, using qualitative methods, which are concrete and part of their everyday experience, by putting them at the heart of the research and facilitating their participation.

A facilitative participative action research project, which takes place over twenty months in a secure setting uses action research, which is described as bringing about action using the research process to produce and monitor change.

In participative action research every member of this group has an equitable say, and in this research all of the participants have equal weight as researchers. The participants include researchers ($n = 2$), who are employed to carry out the research, staff ($n = 10$) who work in the secure unit and the men ($n = 7$) who live in the secure unit.

The main aims of the LS are to explore how the men understand the concepts associated with research, in particular issues of consent, and how they may be more fully engaged with any research they may be involved with. It consists of collecting data through discussion interview and diary entry, whilst engaging together to explore research in terms of the key processes which enable people with a learning disability to understand the nature and ethics of research and to develop a framework for future research aimed at similar populations.

Aims of the Current Research Project upon which the thesis's retrospective data are based.

The immediate aims of this research are:

- To identify the key processes that enable people with complex learning needs to understand:
 - the nature of research;
 - the ethics of research;
 - the possibilities of research;
 - how to make meaning of their research;
 - how to use research findings: the possibilities and the limitations and
 - dissemination of research.
- To consider what effect the involvement of people with complex learning needs has had on the research findings and use of those findings

The longer term developments to which this research can be expected to contribute include: the development of a research framework by means of which disabled people will be able to develop their own foci for research; and by the embedding of participatory research in planning and development relevant to treatment and care within the Trust.

Method

Methods of data collection:

- researchers' diary/journal/observational notes,
- semi-structured interviews,
- focus groups and
- staff and patient ongoing evaluations.

The discussions, interviews and focus groups will cover topics such as:

- What is research and why it might be done
- The difference between research and treatment
- Different types of research
- Levels of participation in research
- Research methods
- Consent to research that could include:-
 - Understanding the research
 - Understanding the implications of research
 - Understanding about confidentiality
 - Asking useful questions about the research - what questions *might they* want to ask and why and what questions *should they* ask and why

- Consent and assent
 - Knowing how s finding are going to be used and how they will be disseminated
 - Who will know you have participated in research and why might that matter.
- Participants took a role in data collection and analysis through;
 - weekly evaluations of the workshops
 - within their discussion during the workshops
 - through the development of the booklet for the LS (Cook and Inglis, 2008; 40).

These topics, coming entirely from the perspective of the external researcher, can be seen as substantive areas to be covered but also must be seen as a springboard for producing new and unexpected topics, perspectives and knowledge when other participants, i.e. patients, become involved. Research participants will have an input into the topics discussed based on their own understandings, needs and experience.

Data to be collected;

- Field notes kept by researcher (and patients or staff if that is deemed appropriate by those patients and staff) on process of developing understandings of research, ethics and consent
- Ongoing tracking/evaluation with patients and staff to plot new understandings and how these have been reached
- 'End of project' focus group discussions with patients and nursing staff in MSU identifying new understandings and how these have been reached
- Individual semi-structured interviews with patients and staff (if deemed appropriate by participants)

Analysis of data will use subject coding and thematic representation. Once a set of themes, concepts, beliefs and behaviours have been identified they will be linked together in theoretical models that emanate from constructs in the data. Participants in the project will be part of the data analysis process, being asked to comment on key themes and identify any gaps or over-emphases in the analysis.

(Taken from Cook, O'Brien, Taylor and Graham. 2004. Proposal to D.O.H).

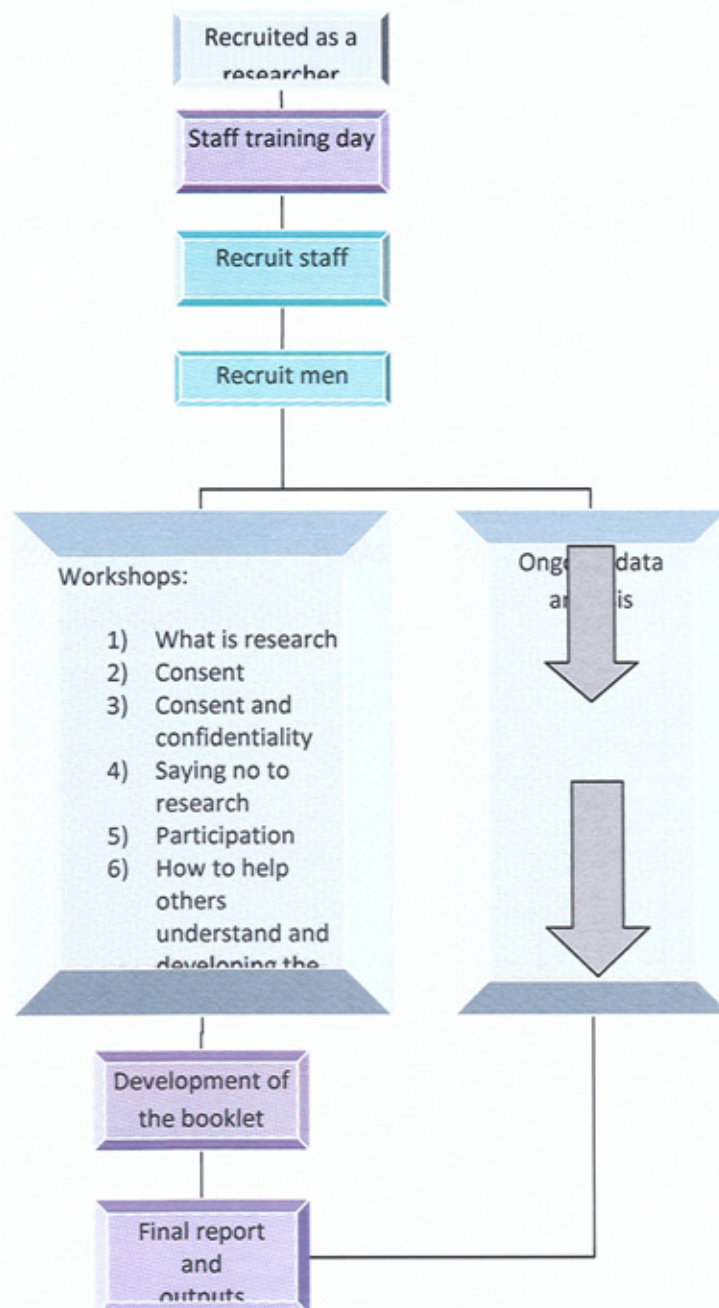


Figure 9: Overview of the research process Cook and Inglis, 2008; 25

Appendix Four: Interview Schedules

Men's Interview schedule baseline.

Semi-structured interview – 14 main questions.

Introduce yourself and note taker.

Remind the interviewee about the research they have consented to take part in.

Preamble about the interview structure, length, tape recording, issues of confidentiality and withdrawal.

Preamble about the project inserted here.

1) Introductions

I just want to begin by finding out a little bit about you and your life.

Just by way of introduction could you tell me a little bit about yourself and your life ?

- i. How would you describe yourself? your life?
- ii. What is the best thing about yourself? What do you do best?
- iii. How do you get on with others at the MSU

2) Beliefs and ideologies about learning disability and nursing practice.

- **Now, I would like you to think about the term learning disability - What do you think about that term/ how does it make you feel?**
 - i. Can you describe what learning disability is?
 - ii. Do you think you have a learning disability? Why?
 - iii. What is it like when people say you have a learning disability?
 - iv. What do you like best about having a learning disability?
- **Try to think about your life here and the nurses who work with you - What do the nurses here do?**
 - i. What is the best thing about nurses here?
 - ii. Do they help you or others? How?
 - iii. Is there anything else you think they could do to help you or others? Or anything else they should do?
 - iv. Is there anything else you would like them to do? Or not to do?
 - v. Are they different from other nurses? How?
- **Again thinking about your life here on the MSU - Do you feel that you have plenty of choice when living here?**
 - i. What choices do you have?

- ii. Which choices would you like to have?
- iii. How might you be able to have more choices?
- iv. Does anyone help you to make choices? How?
- v. Is there anything else that would help you to make choices? Either more choices or better choices?
- **Try to think about a few years ahead - The future.**
 - vi. What is going to be the best thing about your life in the future?
 - vii. If you had one wish, what would you wish for? What would you like your life to be like in the future?

2) Research

Now, I would like to talk about research. Remember back to when you agreed to take part in the research and you were given some written information and a cd with a man called David talking about this research. Thinking about the word research -

- **Have you ever heard the word research? What do you think research is?**
 - i. Can you describe it, or give examples of it? What does it mean to you?
 - ii. Have you taken part in any research?
 - i. Can you explain a little about this and what you did in this research?
 - ii. What did you feel about it, did you like it?
 - iii. Why do you think people do research? What is research for?
- **Why do you think it is important that you take part in this research?**
 - i. Who else do you think should take part in this research?
 - ii. Why do you think people take part in research?
- **How do you feel about being a researcher in this project?**
 - i. What do you think a researcher does?

4) Relationships.

Thinking about this research project and that you will be working as a researcher alongside us and the staff. I would like to talk about how well you get on with people here.

- i. How do you get on with the other men who live here? And the staff?
- **What do you think will be the best things that will come out of working with the other men, the staff and researchers in this project?**
 - i. How do you think that working in this way will affect how you get on - With the other men? The staff? The researchers?
- **Are there any things you think may get in the way of this relationship when we are working together?**
 - i. How can we make that better then? How can we fix it?

5) Consent

The next few questions are about consent – this means whether you agree to take part in the research or not.

- **Do you think that everybody should have a choice about whether to take part in research?**
- **What information do you think people might need to make a choice whether to take part in research?**
- **When might you not want to tell people you had taken part in research?**
 - i. So, what would happen if that person is taking part in that research with you?
- **Have you ever found out the results of any research you have taken part in?**
 - i. Would you like to?
 - ii. What would be the best way for you to understand the results? Written? Pictorial? Etc.

Men's Interview 2.

This interview will be a bit different from the last interview we did.

It will take a narrative approach to collecting information – this means that we don't ask a lot of questions, but just a few important questions, to help you to tell your story of the research from your point of view.

There will also be some pictures to help to remind you about what we did in the research.

Narrative is another way of saying story telling.

1. Please can you tell me the story of your taking part in this research? **Only ask the next questions if not covered in the narrative.**
2. What have you learned through taking part in this research?
3. Can you tell me what research means? – Consent? – Ethics?
4. Which part of the research was the most fun?
5. What do you think helped you learn the most?
6. What was the best thing about taking part in this research?
7. What do you think you did to help make this research a success?
8. What do you think the others did to make this a success? The staff, the other men, Tina and I?
9. If you were asked to take part in a research project now, what would you do?
10. If people were missing from the project what difference would it make? The men, the staff, Tina and I?

Staff Interview schedule baseline.**Semi-structured interview.**

Preamble about the project inserted here.

3) Introductions

- **Just by way of introduction could you tell me about your role in the MSU?**
 - iv. How would you describe yourself, within your role here?
 - v. Can you describe your relationship with others at the MSU?

2) Beliefs and ideologies about learning disabilities and nursing practice.

- **If you had to describe to some one from outer-space, what learning disabilities is, how would you define it?**
 - v. What are the positive aspects of working with people with a learning disability?
 - vi. What do you think may be the positive aspects of having a learning disability?
- **What do you believe are the most fundamentally important beliefs that you have about people with a learning disability which positively affect the lives of the men who live on the MSU?**
 - viii. How do they help your practice and affect the lives of the men who live here?
 - ix. How do you think these have developed practice?
 - x. How do you think these may develop practice?
 - xi. How do you think they have developed your practice?
 - xii. How do you think nursing practice should develop?
- **Are there any nursing models or theories which underpin your practice, like SRV or the social model of disability?**
 - i. How do you feel about these models or theories?
 - ii. How do they affect your practice and ultimately the lives of the men who live here?
- **How do you feel about choice and empowerment for people with a learning disability?**
 - vi. How does this work within the MSU?
 - vii. How has the choice and empowerment of the men been improved or developed?
 - viii. How may the choice and empowerment of the men who live here be improved or developed?

3) Research

- **What do you think research is?**
 - i. Can you define it, or give examples of it?
 - ii. Have you taken part in any research?
 - i. Can you explain a little about this and your role in it.
 - ii. What did you feel about it, did you like it?
 - iii. Why do you think people take part in or carry out research?
 - iv. What is research for?
 - v. Have you ever carried out any research?
 - i. What was it about?
- **Do you know anything about Action Research?**
 - i. Or why it is used?
- **Do you know anything about Participative Action Research?**
If not the interviewer may give a brief explanation.
 - i. How might it work in the MSU?
- **What is the point of people with a learning disability taking part in research?**
 - i. On that basis who should be involved in the MSU?

4) Consent

- **Do you think that every body should have a choice about whether to take part in research?**
 - ii. Do you think that everyone should consent to take part in research or not?
- **What information do you think people might need to make a choice whether to take part in research?**
- **Under what circumstances might you not want to tell people you had taken part in research?**
 - i. So, what if that person is participating in that research with you?

- **Have you ever found out the results of any research you have taken part in?**
 - i. Would you like to?
 - ii. What would be the best way to present the results?

5) Relationships.

- **What do you think will be the most positive things that will come out of collaborating in this project?**
 - i. How do you think that this collaboration will affect your relationships?
 - ii. What about your relationship with the men?
- **Are there any things you think may get in the way of this relationship during collaboration?**
 - ii. How can these be overcome?
- **Do you think this is similar to other members of staff?**
 - i. Would you expect any differences for other members of staff.

Second staff Interview Schedule

The interviews will take a narrative approach to collecting information – this means that we don't ask a lot of questions, but just a few important questions, to lead the interviewee through the story (or the narrative, as narrative is another way of saying story telling) of the research from their point of view.

So the questions are:

1. Please tell us the story of being involved in this research from the beginning from your point of view.
2. Please tell us the story of being involved in this research from the beginning from the men's point of view.
3. Do you now know more about research? Like understanding the terms, research, consent and ethics?
4. Do you think the members of the group know more about research? Prompt – men? Staff? Tina and Pamela
5. How do you think you contributed to the research?
6. How do you think others in the group contributed to research? Prompt as above.
7. What have you got out of your involvement in this research?
8. What is the best thing about being involved?
9. Do you think that there may be any room for improvement in this research?

(Changes made at the suggestion of the men 20/06/06 to create version2).

Appendix Five: Workshop Descriptions

Workshop One: The first workshop aimed to introduce everyone in the group, make people feel comfortable, establish ground rules and discuss what was envisaged for the workshops and the study. The main subject for discussion in this workshop was "What is research?" All of the participants watched the first scene of the DVD, thought about it and discussed what they thought research meant. Some of the group had already taken part in research in the past and offered examples of their experience of this. For most this was either researching through enquiry methods such as using the internet, books, etc. or answering questions set by an external researcher. None of the staff or the men had ever encountered FCAR or been a participating researcher before. The notion of research as a discussion that was captured was difficult to understand and triggered many questions and explanations by participants. During the first session the men initiated a process of supporting each other by trying out different explanations to help a member of the group who had not grasped a particular idea or concept.

At the end of the workshop the participants completed two evaluation forms. One recorded what they had learnt that day, and the other the way in which they had learnt and how they felt they had contributed to the workshop. This was done by using the pre-designed forms. Each person either made marks or stuck shapes in the appropriate boxes representing ideas such as listening, discussing, watching etc. The more marks/shapes they placed in the box, the more important they thought this had been throughout the workshop. This was important information for researchers to gather as it helped provide evidence both of what the participants had understood the workshop to be about and the most effective way of engaging them in the learning.

Workshop Two: Each workshop began with a *resume* of what had been discussed in the preceding workshop. The researchers gave out a *resume* for the participants to keep as a record of what had been discussed. The participants also kept a record and any necessary amendments were noted and included.

Workshop Two focused on issues surrounding consent. The participants watched the DVD and talked about what they understood consent to entail and ways to help people understand what consenting means. The participants then talked about what questions they might like to ask before consenting and the importance of this to the consent process. They decided that it is only when you understand what research is about that you can really give informed consent. They also discussed how they might say no to research.

An example information sheet that had been simplified by making the words easier and sentences shorter was then handed out. The participants discussed how the information sheet could be developed to make it more easily understandable. This included both the need to have background knowledge of research and the use of an easily-read format.

The workshop ended with the two evaluation sheets as above.

Workshop Three: The third workshop began with the *resume* and the participants asked to see the last two DVD scenes, as well as the third scene, in order to help them to discuss this week's planned topics of 'information required for consent and confidentiality'. Seeing all the previous DVD scenes each week became a regular start to the discussion.

The researchers had observed that some members of the group were quieter than others and some needed more time to understand. A discussion was held with staff about the best way to support the men and it was decided to try splitting the group to allow the quieter participants space to contribute.

In the two groups the participants discussed again what they thought research was and went on to identify ways in which it might be helpful to give others information about research to help them decide about participation. The information which the groups thought was important was recorded onto flip charts. The flip chart from each group was read out by participants to the whole group at the end of the session. The workshop was evaluated as above.

Workshop Four: Workshop Four began with a *resume* of the last three workshops and the previous three DVD scenes. As the use of two groups had worked well in the previous workshop, the participants once again split into two groups to discuss issues in respect to saying “no” to taking part in research and how other people might be helped when thinking about saying “no” to research. This topic was chosen as in the first workshop the men showed little understanding of potential consequences to saying no to research when asked to participate by a significant/key person in their lives. The information the groups thought important was recorded onto flip charts and read out at the end of the session by the men. The workshop was evaluated as above.

Workshop Five: Workshop Five began with a *resume* of the last four workshops and watching the DVD scene on different ways of doing research. Then the group split into two and discussed different ways that people can become involved in research, different types of research, the difference between research and treatment. They also began to design a “Dictionary of Terms”. Participants had noted that there were words used that not everyone could understand. Some of these words were particular to research, while others were everyday terms that we understood differently across the group (e.g. text: meaning what has been written down on paper, as opposed to something you send on a mobile phone). This “Dictionary of Terms” was to become part of the information for people with learning disabilities who were about to engage in research.

The information which the groups thought was important was again recorded onto flip charts and the man who had gained recognition as the best reader was invited by the other men to read it out to everyone. The workshop was evaluated as above.

Workshop Six: Workshop Six began with a *resume* of the last five workshops. The participants watched all the scenes on the DVD again before, as a whole group, discussing what they thought information for other people with learning disabilities who were considering consenting to participate in research might consist of. They discussed:

- The aims of the information pack
- What it should look like
- What it should include
- Where it should be disseminated
- Who should be involved in developing it and delivering the information

They then considered how an information pack (now being called “Understanding Research”) could be evaluated. One man had already written down his ideas which included piloting the information before finalising it for dissemination. It was decided that the best way of piloting it would be to deliver it to other men with learning disabilities. The men were keen to act as facilitators to the pilot of the booklet. The pilot is outside the scope of this study but successfully took place in late 2007 and was funded by the Trust¹²⁷.

The group felt that there was also more work to be done on the materials being developed. More workshops were needed to:

- Decide on the most appropriate words and pictures
- Edit the booklet
- Disseminate the findings.

The information which the groups thought was important from Workshop Six was recorded onto flip charts, read out and the workshop was evaluated as above.

Additional workshops: Although six workshops were originally planned, the men requested extra workshops to clarify their understanding of methodology, in particular, the difference between qualitative and quantitative research and collaborative action research. In the course of the previous workshops they had looked at a variety of different ways of doing research and had become more curious about the particular approach in which they were participating.

¹²⁷ The pilot included four of the men who participated in the LS, facilitating the course that was produced, for eight other men in secure settings.

Workshop Seven addressed issues of methodology, the differences between qualitative and quantitative methods and the notion of Facilitated Collaborative Action Research. The latter part of Workshop Seven was used to edit the work done so far on information for other people with learning disabilities (to be developed into the “Understanding Research” Pack) about research and to validate the pictures being used.

The last workshop was used to develop and edit the “Understanding Research” Pack.

(Cook and Inglis, 2008, *Final Report*, pp 35-38).

Appendix Six: Staff Session Plan

Time	Activity	Lead Facilitator
10:00-11:00	Introductions to the project. Research exercise. Introduction to action Research Discussion and feedback	Tina Cook
11:00-12:00	Cave exercise. Discussion and feedback	Pamela Inglis
13:00-14:00	'Are the team listening?' exercise. Discussion and feedback.	Pamela Inglis
14:00-15:00	Action research roundup. Discussion and feedback	Tina and Pamela

Appendix Seven: Staff Focus Group Schedule

1. As a group we would like you to think about the men taking part:

What:

Skills?

Qualifications?

Experience?

Personal attributes?

Do you possess to enable you to help the men to take part successfully?

Could any of the men here have taken part and been successful – why?

What about other people with a learning disability?

2. As a group we would like to think about how you helped the men taking part to take part and learn.

In order to help you to think about this it may be helpful if you discussed the following and came to some consensus about the issues.

Think about your roles here: What
skills ?

Qualifications?

Experience?

Personal attributes?

Do you possess to enable you to help the men?

Could any of the staff here have taken part successfully – why?

Or other nurses?

Or other staff working with people with a learning disability?

3. Thinking about your relationship with the men:

What was the most important aspect of your relationship with the men that led to the success of this project?

What is this relationship which helps you to help the men?

Define it?

Describe it?

Give examples please.

What are the possibilities and limitations of this relationship?

4. So what is it that you did to help the men take part in this project successfully?

What did you do?

What did the staff team do?

What did you say?

How did you act?

Did you do anything that you would not normally do in your role here?

How much time did it take up ?

Give examples please

If you had to write a protocol for a nurse to take part please describe the profile for a nurse to take part in a project such as this:

What are their

Roles?

Skills?

Qualifications?

Knowledge base?

Experience?

Personal attributes?

You may write or draw this person, or describe them verbally.

Appendix Eight: Consent Form

Project Title: Discourse and Forensic Learning Disability Nursing Practice: Ideology, Paradox and Truth



Looking for clues

You have taken part in a research project called:
Understanding research, consent and ethics: a participatory research methodology in a medium secure unit for men with a learning disability
This form asks if the data from this project may be used in another study.



Consent form

I am asking for your consent.

This is a new project for my Doctorate in Nursing Science that has not been done before. I would like to use the data already collected and analyse it in a new way.



Document research

It uses Discourse analysis which looks at the things people say.



what people say

I will analyse the data that we (the men, the staff and the researchers) have already collected and look at how we all talk about issues such as learning disability

Our beliefs

And nursing practice



People with a learning disability

I won't just use our data

I will also use literature and policies from the government



Nursing practice

It does not involve any more work than you have already done in the original study.



Literature



Confidential

You will be afforded the same protection, anonymity and confidentiality that the original study gave you.



Feed back session

It may involve you being invited to a feedback session to discuss the results of the new analysis of the data, which will mean that you will have your say about how the data has been analysed.



Discussions

You do not have to attend this session. You might not be invited to this session.



Saying

No



Getting information

If after hearing all about this, you want more information then tell the staff what else you want to know and I will do my best to answer your questions.

If you want me (Pamela) to come to talk to you about the project, then tell the staff.



Consent form

If you are happy about the idea of the project, you can tell the staff **and/or** sign this letter at the bottom and give it back to them to send to me.

Remember



Yes

You do not have to agree with this project. I would like it if you could because I think it will be interesting.

Not agreeing will have no affect on anything you do or is done with you. It certainly will not affect the way in which you are treated in MSU.

Centre Number: :
Study Number:
Version One: 2007

Consent form



Consent form

The Record of Agreeing to Take Part in this Study

Title of the research project: Discourse of Secure Environments: Learning Disability, Ideology and Nursing Practice (original Title)

I have read/talked with(a researcher or a member of staff) about the above project.

I have decided I would like to agree that Pamela can use the data from the project entitled : *Understanding research, consent and ethics: a participatory research methodology in a medium secure unit for men with a learning disability.* Pamela can analyse the data in a different way for her Doctorate in Nursing Science Thesis.



Yes

I know that:

I may be invited to a feedback session to see what Pamela has found. I can refuse to attend this session

The things I have said as a researcher on the original project have been written down and analysed by Pamela in a different way, but my name



Feed back session



Document research



Confidential

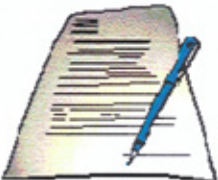


Saying

No



Changing your mind



Consent form

will not be shown on information that goes out of the Unit.

The things I have said in the original project have been tape recorded but no-one will hear that tape apart from the researchers. Once they have listened to it and written things down it will be thrown away. No one will know it was me who said those things.

If I decide not to agree for the data to be used in Pamela's project that is fine, it will not affect the way I am treated in MSU at all.

If I decide to agree but change my mind, then that is fine and it will not affect the way I am treated in MSU at all.

Signed.....

Print Name:.....

Witnessed by.....

1 copy for participant to keep – one copy for the researcher

Appendix Nine: Researcher Interview Schedule

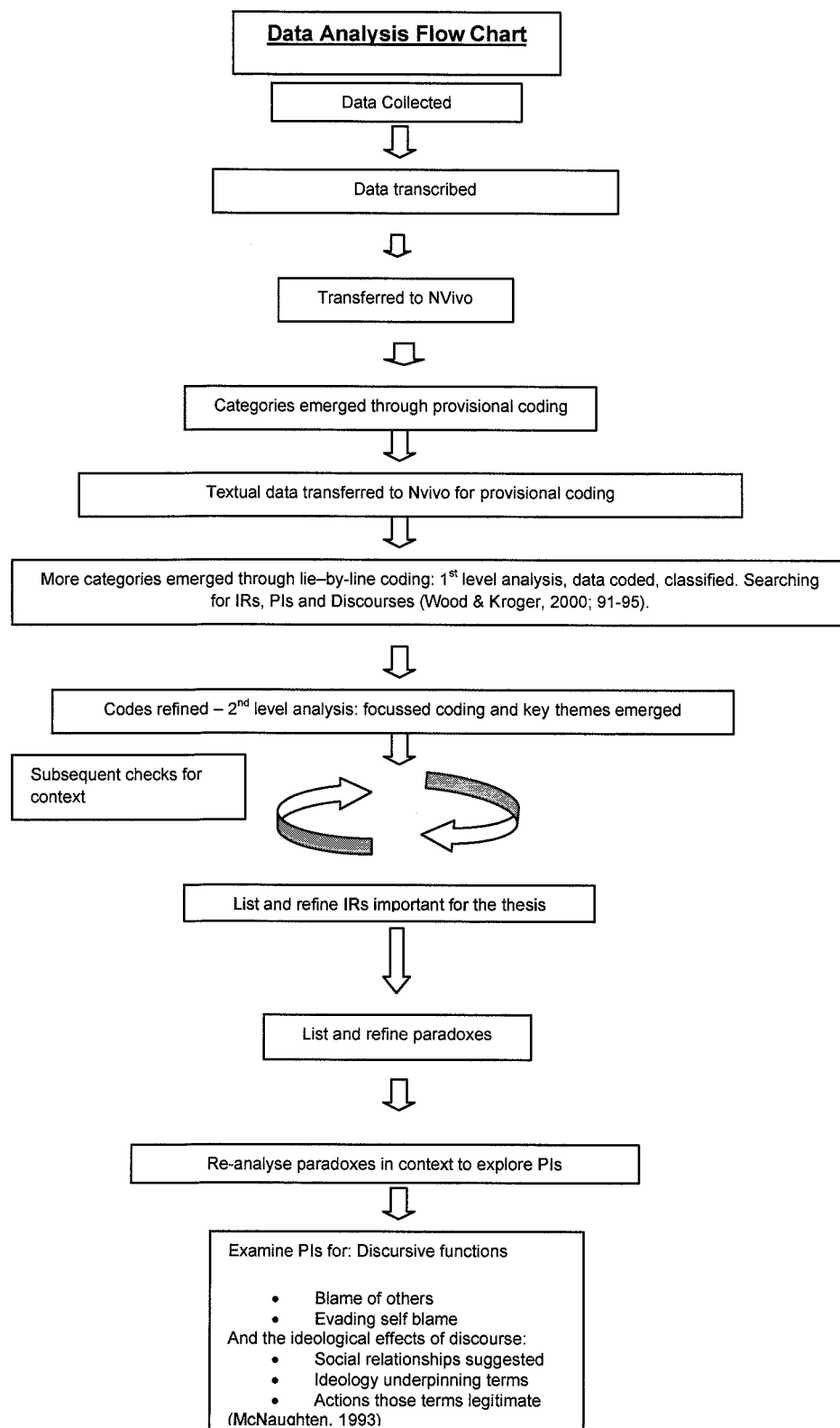
The interviews will take a narrative approach to collecting information – this means that we don't ask a lot of questions, but just a few important questions, to lead the interviewee through the story (or the narrative, as narrative is another way of saying story telling) of the research from their point of view.

So the questions are:

1. Please tell us the story of being involved in this research from the beginning from your point of view.
2. Please tell us the story of being involved in this research from the beginning from the men's point of view.
3. Do you now know more about research? Like understanding the terms, research, consent and ethics?
4. Do you think the members of the group know more about research? Prompt: men? staff? Tina and Pamela?
5. How do you think you contributed to the research?
6. How do you think others in the group contributed to the research? Prompt as above.
7. What have you got out of your involvement in this research?
8. What is the best thing about being involved?
9. Do you think that there may be any room for improvement in this research?

Changes made at the suggestion of men 20/06/06 to create version2.

Appendix Ten: Data Analysis Flow Chart



Appendix Eleven: Node Listing

Number of Nodes: 56

<i>Tree Node</i>	<i>Child Node</i>
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1	(1) /Descriptions of men
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Description:

This node is related to the way in which any of the participants describe the men or anyone with a learning disability. It could include the way the men describe themselves. It could include descriptions of anyone with a learning disability or descriptions of people with a learning disability.

2	(1 1) /Descriptions of men/self description of men
3	(1 2) /Descriptions of men/Best thing about you
4	(1 3) /Descriptions of men/Expectations of men's performance

Description:

This node includes passages that relate to expectations of the men's performance said by any of the participants. It could also include text relating to expectations of people with a learning disability, generally, and not related specifically to the men in this study.

5	(1 4) /Descriptions of men/men's attributes
6	(1 5) /Descriptions of men/experience of having a learning disability
7	(1 7) /Descriptions of men/Future hopes
8	(2) /authoritative corroboration
9	(3) /Relationships
10	(4) /Humour

Description:

This node relates to humour by any of the participants.

- 11 (5) /**Power issues**
- 12 (5 1) /Power issues/security issues
- 13 (5 2) /Power issues/protecting men's' welfare
- 14 (5 3) /Power issues/hierarchy
- 15 (5 7) /Power issues/The Passive Patient

Description:

This node includes passages where participants refer to the men or people with a learning disability as being reliant upon the nurses and carers.

- 16 (6) /**Shouldn't judge on disability**

Description:

This node relates to passages which suggest that people feel uncomfortable in using disability as a tool to judge or differentiate people.

- 17 (6 1) /Shouldn't judge on disability/justifications
- 18 (6 2) /Shouldn't judge on disability/Different from every one else

Description:

This node includes passages where the men or people with a learning disability are described in terms which suggest that they are different to others.

- 19 (6 5) /Shouldn't judge on disability/Just like every one else

Description:

This node relates to passages where participants describe the men or people with a learning disability as the same as others, or use inclusive language.

- 20 (7) /**Experiences of the MSU**
- 21 (7 1) /Experiences of the MSU/Lack of choice
- 22 (7 2) /Experiences of the MSU/Privacy
- 23 (7 3) /Experiences of the MSU/Help make choices
- 24 (8) /**Empowerment issues**

Description:

This node includes passages where participants refer to ways in which the men, or people with a learning disability can be empowered.

- 25 (8 1) /Empowerment issues/choice
- 26 (8 2) /Empowerment issues/empowering men
- 27 (8 11) /Empowerment issues/Empowering the staff
- 28 (9) /**Learning Disability**
- 29 (9 10) /Learning Disability/Negative aspects of learning disability
- 30 (9 11) /Learning Disability/Positive aspects of learning disability
- 31 (10) /**Men's Views of staff**
- 32 (10 1) /men's Views of staff/Staff know best
- 33 (10 2) /men's Views of staff/Forensic nurses different
- 34 (10 4) /men's Views of staff/Negative aspects of the staff
- 35 (10 7) /men's Views of staff/Positive aspects of the staff
- 36 (12) /**What is research**
- 37 (12 1) /What is research/Why take part in research
- 38 (12 2) /What is research/Views of the researchers
- 39 (12 3) /What is research/Who should take part in research
- 40 (12 4) /What is research/Views of research
- 41 (12 5) /What is research/enjoyed the most
- 42 (12 6) /What is research/Positive aspects of joining in
- 43 (13) /**professional discourse**
- 44 (13 1) /professional discourse/medical/professional description of learning disability
- 45 (13 2) /Professional discourse/pause

- 46 (13 3) /Professional discourse/ Informal discourse
- 47 (14) /**Influences**
- 48 (14 1) /Influences/Influences on staff
- 49 (14 2) /Influences/Influence of staff beliefs
- 50 (14 3) /Influences/nursing models
- 51 (14 4) /Influences/Influences on men
- 52 (15) /**Staff issues**
- 53 (15 1) /Staff issues/practical difficulties
- 54 (15 2) /Staff issues/staff role descriptions
- 55 (15 3) /Staff issues/staff training
- 56 (15 16) /Staff issues/caring helping

(Tree Nodes in Bold)

Appendix Twelve: Interpretive Repertoires

Representations of the men

Positive repertoires representing the men as people:

- Like us
- Who should be treated the same as us
- Who go to work
- Who clean their rooms
- Who clean the house
- Who wash and iron

Negative repertoires where the men are represented as people:

- Who are the same as each other but different from others in society
- Who are different from everyone else (“any one can have a mental illness”)
- Who have a hierarchy between themselves
- Who don’t really interact with others
- Different from and the same as us
- Who are different, even to other people with a learning disability
- With different needs
- Of lower calibre
- Who don’t behave well

Learning disability or criminal

Repertoires where the men are represented as people:

- Some of whom need 3 male staff to escort them
- Who are sexual offenders
- Who are dangerous people
- Who are criminals
- That you have to be wary of
- Who are especially dangerous to women
- Who should be observed for security reasons
- Who might cause problems
- With behaviour to be managed
- Criminals, not men with learning disability
- With criminal behaviour
- Who have to be separated from society
- We have low expectations of
- Who might steal cutlery, pens etc
- Whose visitors should be checked
- Whose rooms have to be searched

Repertoires representing the men as people:

- Who will only join in if they could get something out of it
- Who may be excluded from research because of lack of ability
- Who can be denied opportunities because of their skills, understanding, willingness to participate, their behaviour, their potential for disrupting
- Who can work under supervision
- Who it is surprising that they function at a high level

Passive patients

Repertoires representing the men as people:

- Without an opinion
- Who are passive
- Who are patients

Repertoires representing the staff**Positive representations as people who:**

- Wouldn't just join in because they could get something out of it
- Will solve problems not create them
- Are familiar to the men
- Are someone whom the men trust
- Builds trust with the men by helping them
- Help the men
- Work in a paradox of caring for the men, whilst locking them up
- Try to build relationships without revealing too much of themselves
- Can communicate on the men's level
- Job it is to observe the men
- Check for contraband objects (such as pens)
- Count the men
- Hold meetings for the men
- Believe movement into the community is the biggest improvement in the care of people with a learning disability
- Can get more out of the men
- Are good team members
- Are good managers
- Are willing to listen
- Have little hierarchy amongst the staff
- Help each other out
- Respect each other
- Expect certain levels of behaviour from the men
- Help the men to learn
- Help the men in between the sessions, by repeating the information discussed
- Encourage the men
- Take the men to work

- Help with their daily living skills
- Help with their social skills
- See to security (Counting cutlery, checking visitors, checking contraband, checking rooms, etc)
- Can decide what the men's choices are
- Understand the balance between giving choices and what is practical
- Feel it is important that the men have choices
- Know the patient
- Know how they work and live
- Should be male staff so that they can supervise the men
- Should be responsible for checking the men's inappropriate behaviour
- Acknowledge the men have different stresses to others
- Acknowledge the negative aspects of having a learning disability and the extra stresses they may encounter
- See professionals and society as helping the men
- Form friendships with the men
- Look past the men's criminal past
- Look at who the men are and why they might have done what they have done
- Have insight into how they come to be in the MSU
- Would like to form friendships with the men, but feel that they cannot give them personal information because of risk
- Have to occupy the men to protect them from getting bored and getting into trouble
- Keep the men cheerful
- Teach the men skills
- Give the men structure
- Describe the grading system as a reward system, but explain it as a punishment
- Describe choice as good, but restricted because of the men's behaviour/risk
- Sometimes lean more towards therapy (more educated and those who have been there shorter lengths of time)
- Like to spend more one-to-one time with the men
- Would like to give more attention to those who behave well, rather than those who don't
- Have a good relationship with the men
- Men admire
- The men like
- Use their sense of humour with the men
- Are professional
- Care deeply for the men
- Want the men to improve
- Take pleasure from the men increasing skills and achieving
- Do extra tasks for the men, outside of their duty, such as going to shops for the men, carrying out extra work

Negative representations of staff as people who:

- Do not give the men who behave as much attention as those who do not behave well
- Sometimes lean more towards security
- Describe rewards as simple privileges such as listening to music, watching dvds and cooking.
- Describe the men by their level of learning disability
- Might upset the power imbalance in focus groups through intervening
- Believe that safety and security supersedes empowering the men through research
- Wear clothing symbolising authority
- Believe that it is difficult to make the men understand the simplest of things, such as pairing socks
- Yet believe that the men are “planners”
- Believe that they should be involved in research before the men are asked to join in
- Can choose who is given the opportunity to take part in research
- See the men as living a sheltered existence
- Believe that researchers are in danger of sexually inappropriate behaviour from the men
- Justify the lack of choices through the law and Home Office
- Might over- or under-estimate the men’s ability because of their IQ scores
- Can choose who should be able to take part in the project
- Cannot see a positive in learning disability and living in the MSU
- See the men as lacking in opinion and understanding
- See the men as posing a security risk
- Lock people up
- Are prison wardens
- That patients distrust
- Shouldn’t reveal too much of themselves (personal information) to patients
- Are required to supervise patients
- Advise and warn about dangerous patients
- Are surprised at the level the men can work at

Experiences of MSU**Repertoires representing the men as people:**

- Who receive the specialist treatment they require
- Who miss their friends and families
- Who think that they should not be in the MSU
- That can’t go out even when they have earned it because of staff shortages
- Detained under the Mental Health Act
- Separated from their loved ones

Positive repertoires where the men are represented as people:

- Who are offered choice
- Who should be part of patient groups
- Who should be part of CPA and MDT decisions about their care
- That will understand things such as research, if they are explained properly
- Who should be asked about their care

Negative repertoires where the men are represented as people:

- Who may be confused by having a lot of choices
- Who can't take in a lot of information
- Who should not always be empowered
- Who can't take in a lot of information
- Who like others to make choices for them
- Who sometimes cannot make decisions
- Who might make the wrong choices
- For whom structure is important, but has been historically missing
- Who need occupying
- Who need to be kept cheerful
- Need to be taught skills
- Who would stay in bed and turn day into night, without any structure
- Who have limited choices as they have to consider others' preferences
- Have limited choices because of living in the MSU
- Have to be "ok" to make choices
- Can't make some choices because of the section of the MH Act they are held under

Repertoires of Social Role Valorisation, Affirmation, Valuing People and policy

Choice

Independence

Inclusion

Rights

Authoritative corroboration

Protection

Victim

Appendix Thirteen: Paradoxes and Binary Oppositions

<p>A. THE MEN:</p> <p>A.1 Difference and Sameness: The men are different from other people with a learning disability</p> <p>A2 Stresses of Living: The men live sheltered lives and do not have the same stresses as others</p> <p>A3 Dangerousness and Vulnerability: The men are victims</p> <p>A4 The Paradox of Ability: The men are viewed as planners</p> <p>A5 The Paradox of Expectation: The men are viewed as having low skills and understanding</p> <p>We expect a certain level of behaviour from the men</p> <p>B. FORENSIC PRACTICE:</p> <p>B1 Caring whilst detaining: Caring for the men</p> <p>Claim biggest improvement is community living</p> <p>B2 The Security Paradox: Supervise contraband objects such as pens</p> <p>B3 The Relationship Paradox: 1 Staff would like to form personal relationships with the men</p> <p>Staff acknowledge the importance of building relationships</p> <p>B4 The paradox of Choice: 2 Choices are restricted because of security risk and section</p> <p>Choice is limited because of the men's ability</p> <p>Limits in choice shifts and is justified by the men's behaviour</p> <p>B5 The Paradox of Participation: Staff believed understanding and commitment were important in choosing participants</p> <p>Believe that the men should be supervised during interview as they are dangerous</p> <p>B6 The Paradox of Reward: 4 Men who behave do not get as much staff attention</p>		<ul style="list-style-type: none"> - yet they are the same as other people with a learning disability - but they have lived terrible lives and have backgrounds of physical, psychological and sexual abuse - yet they are also perpetrators - yet are viewed as not being able to carry out simple tasks - yet there are high behavioural expectations which are observed and policed - yet when they behave accordingly, they do not always receive the rewards they are entitled to - yet being part of the system which locks them up - yet their job is to lock people up in hospital - yet describe them as 'silly things' - but cannot because of risk - whilst giving little of themselves - yet choices become less restrictive because of policy change, even though risk has not changed - yet the men are expected to behave to a standard which they understand for the grading system to work - yet different staff make different choice limitations - yet chose men of whose understanding they had low expectations, being more concerned with behaviour and security, than ability - yet ask if they mind someone being there 3 – believing it important for the men to have their say - men who behave badly get more staff attention
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1. This paradox concerns relationships. It is entirely useful and usual to form close relationships with people you care for over long periods of time: in fact the staff here claim the importance of such relationships in helping the men. However, they also perceive that they cannot form close relationships, especially whilst giving personal information (e.g., about their children) as the men pose too much of a risk.
2. The fourth paradox concerns choice in the MSU. Staff claim that choice is limited because of certain criteria believed to be important for success; but actually those people whose behaviour was more suitable, rather than relying on the chosen criteria.
3. If they agree, they can be interviewed. If not, they can't.
4. Concerns the staff giving more attention – commonly viewed as a reward – to the men who do not behave appropriately.

Appendix Fourteen: Positive Aspects of the Men Found in the Data

The men were reported to be:

- Talented
- Intuitive
- Self-aware
- understanding
- A good character
- Caring and loving
- Bright and enthusiastic
- Hard working
- Helpful to people, each other and to the staff
- Offer peer support
- Of good personality and character
- Just like everyone else
- An ordinary guy
- Entitled to the same rights and choice
- Hoping and wishing for the same things as everyone else
- People who strive for success
- Experts in the LS
- A good laugh

The men were reported to have the following abilities:

- Insightful towards others
- Artistic
- Co-researchers
- Gain accreditation of 10 credits at level 3 from University
- Act as facilitator for others to learn about research
- Speak at national and international conferences
- Coach others
- Effectively use given opportunities
- Demonstrate to others that low expectations are wrong
- Work as equals
- Contribute to academia
- Have brilliant ideas
- Overcoming difficulties
- Enjoying learning
- Try really hard
- Use humour effectively so that everyone enjoys the work
- Making work more enjoyable for others
- Overcoming impairments and disabilities
- They have insider knowledge
- A unique perspective

Learning disability was found to be positive as:

- It brings elements of fun to work
- It means that the men were experts in learning disability
- The men were the most important in the LS
- People without a learning disability do not know as much as people with a learning disability

- There is a positive in-group image
- They have unique attributes
- They receive opportunities that others are denied
- They receive extra help and specialist treatment and may take treatment more slowly
- They are less stressed and sheltered from certain stresses
- They have a simpler world view
- They have less responsibility and can concentrate on themselves

